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Sonoma Medicine

LESSONS LEARNED

WARTIME MEDICINE

WILDFIRES

OPIOID TASK FORCE

COVID-19

HOSPITALS AND HEALTH CENTERS

SOLO AND SMALL PRACTICES

DR. SUNDARI MASE INTERVIEW



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The magazine of the Sonoma County Medical Association
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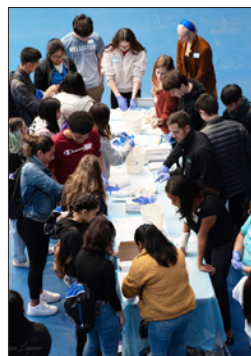
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SONOMA COUNTY MEDICAL ASSOCIATION

Mission: To enhance the health of our patients and community; promote quality, ethical healthcare; and foster strong patient-physician relationships and the personal and professional well-being of physicians through leadership, partnership and advocacy.



MENDOCINO-LAKE COUNTY MEDICAL SOCIETY

Mission: To promote and develop the science and art of medicine and the care and well-being of patients; conserve and protect the health of the public; and promote the betterment of the medical profession.

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SCMA Membership

Active members 702
Residents 50
Student 1
Retired 250

MLCMS Membership

Active members 29
Retired 28

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The equipment is available to all qualifying physician practices, whether or not they are members. Reserve your PPE by signing up at cmadocs.org/PPE no later than July 21. PPE will be available via a drive-through event on July 30 in Sonoma County (date TBA for Mendocino and Lake). Details regarding pickups will be provided closer to dates.

For more information, see [CMA's PPE Relief Project Frequently Asked Questions](#).



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A Time of Crisis, Response and Dedication to Mission

Is anyone else exhausted by 2020? I am spent. Spent from lack of community connection that feeds my extroverted soul. I miss our wellness hikes, our Women in Medicine gatherings, and Physician Appreciation events. I miss working side by side with the SCMA team, the board of directors and our House of Delegates representatives. We are still connecting via Zoom, but it's not the same. Although we haven't been able to gather and socialize, rest assured, the SCMA team and leadership have not rested.

Amidst the chaos, with the help of the editorial board and a myriad of contributors, we've managed to compile and publish this summer 2020 issue of *Sonoma Medicine*. To the original theme of Lessons Learned (fire recovery, youth vaping, wartime medical care, MAT addiction treatment), we added a second focus on COVID-19—covering impacts on solo and small practices, hospitals and community health centers. An interview with Sonoma County Public Health Officer Dr. Sundari Mase rounds out the section. Protests, events and other topics of interest to the medical community are also included in this important issue.

The pandemic put a great big fire under SCMA and the California Medical Association. But that is to be expected, right? Organized medicine leaders have trained our entire careers to be able to serve our local physician community and pivot to provide help wherever necessary in times of great need. Everyone has been working overtime with issues affecting California physicians

and practices. Governor Newsom looks to CMA for advice on most things related to health and wellness: from telehealth reimbursement, to community masking, to protecting our public health officers from harassment. We are happy to be advisors and advocate on your behalf.

I asked our CMA legislative team (state and federal policymakers) to share their top significant wins for California physicians since the beginning of the pandemic. See their list and links to resources and support at the end of this letter. Advocacy matters!

This pandemic has reminded us how quick and nimble we can be. Our thoughts have been focused night and day on helping practices thrive and/or survive, with survival being the main concern for many. Aside from telehealth and funding, our initial focus was identifying a volunteer workforce to have in place and ready to serve when and where necessary. In this case, the priority was creating malpractice exposure sanctuaries for frontline healthcare volunteers, which was critical to identify in the first few weeks/months of the pandemic so we could appropriately advise our volunteer workforce.

CMA was involved in the initial phase of the Care4Caregivers Now program. What was initially to be a program for SCMA/MLCMS physicians, went on to become a statewide initiative and long-range plan for physician wellness, managed by CMA. The team quickly acknowledged that it was crucial to provide alternative housing and wellness for frontline caregivers so no providers had to chance infecting their high-risk loved ones at home. After much analysis and discussion, the grassroots program quickly became bigger than SCMA. Our ideas were taken to

like-minded professional associations for support, and then went on to the governor's office where the program was approved as a statewide initiative that is still very much active. [Click here](#) for full details.

When the initial problem was a lack of PPE and N95 masks, SCMA became an advising partner for a small group of sewists who wanted to make handmade masks for the physicians and medical staffs. Through social media outlets, we quickly grew from 300 to 1,300 volunteers. At last count, we have donated 19,183 masks, 1,201 ear savers, 395 face shields, and 605 scrub caps to various hospitals, medical groups and solo/small practices in Sonoma County. We also provided masks (at no charge) to grocery store employees, daycare facilities, retirement homes, fire and police personnel, and just about anyone who asked for them. Volunteers continue to sew for requests that trickle in. We took in a few donations, which were helpful in purchasing supplies to continue the efforts, but this was not a for-profit venture for anyone. Our group of sewists gave away more than 19,000 masks before it became mandatory to wear them! [Read more here.](#)

CMA partnered with the [Redwood Empire chapter of the American Institute of Architects](#) to make face shields for Sonoma County physicians. To date, we have delivered over 400 face shields to local practices. [TLCD Architecture](#) remains willing to 3D print and laser cut face shields if needed. Isn't it great when the professional community comes together to support one another? CMA/SCMA/MLCMS have an outstanding PPE initiative in the works (we are organizing the process and ironing out the wrinkles,) that will provide solo/small medical practices with a 60-day supply



Wendy Young is the executive director of SCMA and MLCMS.

of PPE to help reopen offices, protecting staff and patients. Keep an eye on my newsletters for details as they are released. Our PPE distribution event is currently scheduled for Thursday, July 30, 2020. With enough response to the survey from Mendocino Lake County physicians, we will hold a similar PPE distribution event with our rural sister chapter.

SCMA supported local physicians in the White Coats for Black Lives peaceful march in early June. (See page 10.) I was inspired to see (the eyes of) many local physicians and board members who turned out on the greens of the Santa Rosa Junior College and marched to the Sonoma County Sheriff's office, right down the middle of Mendocino Avenue.

It was interesting to see cars patiently waiting for the large congregation of masked, white-coated "protesters" to march by. I expected more pushback for us blocking the street, but obviously our community gets it.

SCMA's president, our board of directors, I and the entire SCMA team stand in solidarity with our black community, all persons of color and of all ethnic groups, genders and spiritual beliefs. Racism and acts of violence are against everything we stand for and have no place in our world. All medical practices and groups must do their part in creating a fair, equitable and just medical community. Our mission is protecting and saving lives and making our communities healthier places for everyone.

Through all of this, **we were here for you**, albeit quietly in the background. I really felt that one of the best things I could do for the medical community was to stay out of the way, but keep my eyes and ears open to what was needed. It has been rewarding to see our community working together for the greater good. Through all the chaos that Sonoma County has experienced in the last several years, it is always YOU who race to the frontlines. I am blessed to be associated with such a dedicated, selfless group of professionals.

Yours in health,

Wendy Young

Email: exec@scma.org

Home office: 707-620-0808

CMA Initiatives and Resources for COVID-19 Support

Financial

Congress and the Department of Health and Human Services (HHS) have provided more than \$3 trillion in aid through four pieces of legislation and administrative waivers. CMA's goal at the federal level is to protect the public health and the financial viability of California physician practices. Article links below:

- [\\$175 billion Provider Relief Fund: Direct payments to physicians](#) (**Note:** The Heroes Act that just passed the House would provide an additional \$100 billion in the Provider Relief Fund; the new funding formula covers 60% of physician revenue losses from all payers and 100% of COVID-related costs.) Read more here.
- [2% Medicare payment increase and Medicare advance payments](#)
- [6.2% Increase in federal Medicaid funding \(new House bill provides 14% increase\)](#)
- [\\$660 billion in small business loans: Paycheck Protection Program forgivable loans](#)
- [\\$500 billion Main Street Lending Program for physician practices](#)
- [Billions in tax credits for small businesses, including physician practices](#)

Practice Support and More

- Practice financial viability: COVID-19 has threatened many practices with financial insolvency. CMA has been strongly advocating on behalf of physicians, making sure that government agencies understand the immediate and ongoing need for financial assistance for physician practices. CMA also ensured [protection of Proposition 56 tobacco tax-funded healthcare programs and services](#) in the 2020-21 state budget.
- Access to telehealth: As the medical community responded to the COVID-19 public health emergency, many physicians looked to

implement telehealth in their practices so they could continue safely serving their patients. CMA worked quickly to ensure that policymakers and payors provided the necessary [telehealth flexibility](#), payment parity, and [security and privacy](#) waivers so physicians could immediately incorporate telehealth tools into their workflows.

- [Medical student loan payment deferral](#): Senate bill included many California and Texas physicians initially excluded from the program because of state laws.
- Providing COVID-19 clinical information: [CMA was chosen to partner with the California Health and Services Agency](#) and academic medical centers across the state to host the California COVID-19 Clinical Updates, a regular series of virtual grand rounds for the state's clinicians on the evolving understanding and management of COVID-19 patients. [The first of the series](#) was held on July 14, 2020.
- Reducing regulatory burdens: As California prepared for a potential COVID-19 surge, physicians needed flexibility to quickly respond to calls to reinforce COVID-19 frontlines. CMA helped streamline regulatory requirements for things such as [waiving licensing requirements that could have slowed down providing care where it was needed](#).

■ Strong public health approach to COVID-19 response: CMA has been at the forefront of seeking to ensure that the state takes a strong public health approach to COVID-19. Early on, CMA urged the Governor to declare [a public health emergency to allow flexibility for the state and locals to respond](#) appropriately to the quickly unfolding crisis. CMA also sought the [establishment of a statewide face covering order](#) when it became clear that some local jurisdictions were allowing politics to eclipse science.

For current information regarding CMA initiatives and programs, check CMA's website for daily updates and news. www.CMAdocs.org

Careful Reopening a Must Going Forward

As current leader of your medical association I share with a majority of our member physicians a collective outrage over the recent treatment of African-Americans and other minorities at the hands of our nation's law enforcement. For far too long these groups have been treated as second-class citizens by those who should, and do, know better. Racial injustice has no place in our society, in our government, or in our personal lives. However, on the positive side of the ledger, we applaud the recent landmark victory for the LGBT community in the Supreme Court's June ruling that makes it illegal to discriminate against employees based on sexual orientation or gender identity.

The coronavirus outbreak will have lasting effects, both on our health, and on the near-term practice of medicine in our region and the United States as a whole. While the larger medical provider groups in Sonoma County have largely retained their full staffing levels in the wake of the community "lockdowns," our smaller, solo medical practices have suffered greatly, due to patients' reluctance to seek out not only emergency services, but also routine, scheduled visits. Tragically, some of

our seniors have been fearful of even visiting their local pharmacies



SCMA President Dr. Ranadive serves as medical director, Sonoma County, for St. Joseph Health Medical Group.

to take delivery of important medications during lockdowns, including those used to treat heart ailments, diabetes, and other chronic conditions.

While we will never know how many of our patients were at serious risk due to the fear of seeking necessary medical attention, we must now look cautiously forward to a reopening. Although the detection of new cases is rising in

**Dr. Sundari Mase
deserves both
credit and our
gratitude for
"staying the
course" ...**

Sonoma County, purportedly related to the County's increase in COVID testing, we anxiously await the days of caring for our patients and the understanding among our community that it is safe for them to visit their providers. Never again do we wish to face a set of circumstances that puts our population at serious health risk—from not just a virus itself, but from the sometimes

exaggerated fear and inaction resulting from a viral outbreak.

Coincidental with the reopening should be an examination and remediation of the inability of our seniors to access modern telehealth options. Many members of this demographic were made to feel excessively fearful of any in-person medical assistance because of blaring headlines, COVID case counts, and death totals on major TV news programs. Had these seniors the knowledge and the technology to do so, they could have taken advantage of telehealth options, including Zoom meetings with medical providers, to address necessary, day-to-day, health-care concerns. Our leaders in technology and in healthcare need to step in and create an easy-to-use, "one-button" senior platform. This could perhaps be analogous to the "Ring" wireless doorbell camera technology, and would facilitate user-friendly telehealth delivery to the most vulnerable and often technology-challenged among us.

The time expanse between March and June of 2020 saw the North Bay, the country, and much of the civilized world in uncharted territory. Nevertheless we continue to hope that our communities will emerge comparatively unscathed from the COVID epidemic. Compared to infectious "hot zones" in the northeast and parts of Europe, by contrast Sonoma, Mendocino, Napa, and Lake counties appear to have dodged the proverbial bullet in terms of the number

of cases as well as the number of deaths. And, as in other parts of the world, the very unfortunate fatalities seen here were often complicated by the presence of other, secondary medical conditions in these patients.

And credit for these comparatively small numbers goes in large degree to our public health leadership, whose members have placed safety precautions over expediency at every turn, often in spite of outspoken opposition. Sonoma County Public Health Officer Dr. Sundari Mase has been emblematic in this regard, and deserves both credit and our gratitude for “staying the course” even in the rough-and-tumble of the public square. Similar expressions of recognition are due our non-public healthcare provider leadership. Whether

it be our large hospitals and medical institutions, or the small group and solo practitioners, all evidence points to an assemblage of premier physicians who are going to great pains to exercise both compassion and common sense to keep the North Bay safe during this pandemic.

Finally, it is very important for all physicians in our community to pay attention to the recent street protests, for two reasons. The first is our collective concern that these mass gatherings not result in a spread, or what some have referred to as a “second wave,” of the coronavirus. After all the illness, death, and economic hardship our country experienced in this year’s second quarter, the very last thing we need to suffer would be a similar fate a second

time around. The second reason is that these demonstrations are highlighting the need for all of us to educate ourselves on the ethnic sensitivities of our diverse patient populace.

As physicians our first and most important duty is to preserve life. To properly fulfill our commitment to that duty, we must always strive to understand not just our patients’ physical health and well-being, but their spiritual and cultural aspirations, as well. When both ends of that spectrum have been fully addressed, we can rest easy, knowing that we have done our jobs to the very pinnacle of our abilities and training. ■

Email: rajesh.ranadive@stjoe.org

White Coats for Black Lives

On Saturday, June 13, physicians, medical workers and supporters marched from Santa Rosa Junior College to the Sonoma County Sheriff’s office and then to Courthouse Square. It was a peaceful demonstration in support of the Black Lives Matter movement.



Dr. Patricia May, immediate past president of SCMA, and one of the march’s leading participants, stated, “Our community and nation are hurting from the recent horrific deaths of George Floyd, Breonna Taylor, and Ahmaud Arbery, to name a few. These events are tragic. I am heartbroken to learn from my colleagues of the many daily injustices that still occur in our society and world because of color.

I was honored to stand in support of Black Lives and to call for the end of systemic oppression and racism. I feel we must be more engaged in our spheres of influence to root out inequalities and bias; we cannot be passive. We need to listen and be willing to engage in difficult conversations to eliminate any bias in all aspects of our world. As a physician, I am committed to racial equality in the healthcare setting. I seek to do my part to eliminate healthcare disparities and make this a better world for all.”

Patricia May, MD, FACS
Assistant Chief of Surgery
The Permanente Medical Group



Dr. Regina Sullivan, past president of SCMA, said, “I had a rewarding time standing with my colleagues to bring attention to racial injustice. It was heartwarming, powerful and humbling to see so many members of the Santa Rosa community come together to support Black Lives. As a physician, I am committed to racial equality, within the healthcare setting as well as outside of it.”

Regina Sullivan, MD, MBA, CPE
Obstetrics/Gynecology
The Permanente Medical Group

Mendo-Lake Mini-Surge Follows Sonoma

While MLCMS is not experiencing the case surge seen by our sister medical society to the south, we are facing our own set of health challenges. Mendocino and Lake counties have seen what is being called a “mini-surge” of COVID-19 cases since late June, approximately three to four weeks behind the surge in Sonoma County. At press time the count is 155 cases in Mendocino County and 122 cases in Lake County.

Some attribute our mini-surge in part to a group of local residents who visited the Bay Area and then returned to their hometown of Covelo, a small, lovely hamlet that also serves as home to the Round Valley Indian Reservation. It is suspected that this group may have contracted the virus during their travels and brought it back with them.

Much as with the occurrence of infections, the availability of COVID testing in Mendocino-Lake has lagged behind that of our more populous neighbors to the south. Testing in our region became an option approximately two to three weeks later than in Sonoma County. There is now one testing location in Ukiah, another in Lake County, and a third at the Mendocino Coast District Hospital in Fort Bragg. In an effort to underwrite the overhead costs associated with the testing locations and to ensure their continuation, there is a big plea being voiced to our residents to “take the test.”

The rough math indicates that about 130 tested residents



Dr. Joseph is a radiation oncologist in Ukiah and serves as president of the Mendocino-Lake County Medical Society.

per day are needed to justify continuation of the program. To date in July, Lake County has 122 cases out of 5,609 total tests; Mendocino has 155 cases out of 12,473 tests—as compared to 1,886 cases out of 61,328 tests in Sonoma County. The virus does not appear to be going away any time soon.

Sadly, our rural community lost our only ear, nose and throat (ENT) practice, a casualty of COVID-affected contractual negotiations that are, unfortunately, occurring nationwide. Until a suitable local substitute is found, ENT patients in our region are being referred to NCMA in Santa Rosa and a practice in St. Helena. On the plus side, Mendocino County recently gained a second urologist for our area.

Also a positive development, the Mendocino Coast District Hospital recently took on new and outside management. Adventist Health, one of the nation’s largest rural healthcare providers, took the reins on May 4, and the renamed facility is now Adventist Health Mendocino Coast. “We’re excited to join Adventist Health and its broad network of hospitals and clinics. Their commitment to improving access to care in rural communities and reputation for providing exceptional care makes them a perfect partner for our community,” commented interim CEO Wayne Allen in a press release. “Becoming part of Adventist Health’s system will allow for delivery of more coordinated care throughout all of Mendocino County,” he added.

Our scenic region is not immune from the unfortunate byproducts that have occurred across the nation in the wake of the extended lockdowns associated with combatting COVID-19. According to the Ukiah Daily Journal,

Mendocino County has seen a dramatic rise in domestic violence cases, double what was reported for the same period in 2019. Associated with this is a substantial increase in emergency protective order requests and temporary restraining orders. We are hopeful that these numbers will fall when lockdown restrictions are eased, and our region can begin the slow “return to normal.”

All in all, we are thankful that our medical community has been able to handle the comparatively low impact COVID has had so far on our rural communities. With its abundance of natural beauty, Mendocino is heavily dependent on tourism, and its numerous hotels, B&Bs, restaurants, bars, and tourism-related businesses are “champing at the bit” to return to the life we all once knew.

* * *

On the MLCMS leadership front, I am pleased to announce that **Dr. James O’Dorisio**, thoracic surgeon in Ukiah, has accepted the role of president-elect on the MLCMS Board of Directors. Dr. O’Dorisio moved to California from Michigan in 2005, working briefly at Kaiser Permanente. He was in private practice with Northern California Medical Associates from 2007 until 2014, before moving to Ukiah where he is currently practicing. Please join me in welcoming Dr. O’Dorisio to the MLCMS leadership team. You may soon be getting a call from one of us inviting you to join the MLCMS leadership adventure.

May the appreciation we now have for things once taken for granted remain with us, for a good long while. ■

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- Medical Care in Wartime
- Psychological Impacts of Protests
- Field Report: 2019 Kinkade Fire
- Harm Reduction: Opioid Use
- Harm Reduction: Vaping

Providing Medical Care

Misty Zelk, MD

During my previous career as a physician serving in the United States Armed Forces, I participated in two significant deployments that helped shape my medical practice and philosophy to this day. The Iraq War and Hurricane Katrina both resulted in significant levels of injuries and fatalities, not to mention widespread destruction and psychological aftereffects.

The lessons learned from those two experiences were manifold and useful today as we healthcare professionals deal with the Coronavirus outbreak. The first is that consequential medical advances are often made in stressful, wartime environments for one simple reason: as a medical professional, you have to do your best using the manpower and materials available. Necessity is the mother of invention, and when supplies and equipment are in short supply, you must make do. The sophisticated equipment, robust infrastructure, and testing protocols we tend to take for granted in peacetime are in fact often unavailable luxuries during a crisis.

The second lesson is that, in order to do your job to the best of your ability, you must learn to deal with your emotions as conflict rages and fatalities rise. Upon arriving in Iraq in 2004, I fully admit to having been initially overwhelmed by anxiety and panic in my first exposure to armed conflict. As explosions and gunfire raged not far away, physicians and nurses treated our brave soldiers who had lost organs, limbs, and, too often, their lives. The sights and

sounds of medical peers conducting themselves



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Win Wartime

in an unflappable manner under such circumstances were both unforgettable and highly instructive.

Thirdly, effective communication using common terminology and employing alternative information strategies is key to success in a crisis. When we deployed to New Orleans in the wake of Hurricane Katrina, the Federal Emergency Management Agency (FEMA) and other non-governmental organizations (NGOs) serving in the region were

their respective branches, to overcome large-scale emergencies. Post-Katrina we learned that all groups that might be called to serve need to train together: FEMA, the military, and the host of NGOs that come into service to provide supplies, aid, and other vital support functions.

Today as we are faced with the ravages of COVID-19, the availability of social media and the alternative information sources it offers provides

**Keep your head down and treat only the patient in front of you at the moment.
Keep your focus.**

all employing different descriptors and “lingo,” leading to confusion and miscommunication. Worse still was that there was no “unity of command” among these various non-military groups and the local and state governments: no one was in charge. Having done no preparation whatsoever, local leadership resorted to pointing the finger at Washington, which acts as the third and final line of defense in such crises. While interested readers are welcome to look up the term, Katrina was what military personnel refer to as “FUBAR.”

A fourth lesson in the wake of Katrina changed the way the various branches of the U.S. military train for such events, as well as the ways in which they interact with civilian peer groups. Prior to this massive hurricane, the various branches trained very effectively, yet individually within

a powerful combination. Earlier this year I was made aware of a group of ER physicians, hospitalists, and intensivists who had formed an informal information-sharing network on Facebook to address coronavirus. In contrast to “official” guidance from CDC and WHO that has proven confusing and at times contradictory, this group allows peers to share real-world information from the start of presentation through different treatment phases. The ranks of this group have since greatly expanded to include epidemiologists and other medical professionals with meaningful data.

The socio-political elements of this pandemic are profoundly disturbing. According to a report issued by its own government, the People’s Republic of China (PRC) purchased 2 billion surgical masks and 25 million pieces

of protective clothing from worldwide sources in January 2020. It was during this period that the PRC also rejected repeated offers from the World Health Organization (WHO) and the Centers for Disease Control and Prevention (CDC) to send experts to assist with testing and treatment. Bear in mind that the PRC itself already manufactured fully half of the world’s annual mask supply, even before placing its extraordinary order. Government and investigative authorities have since confirmed that at least a month expired before the Chinese disclosed the deadly nature of the virus to the rest of the world. Countless lives were unnecessarily lost as a result.

I could go on, but the point to our healthcare community is to try to block out such troubling considerations for now. Political leaders and policymakers will deal with it at the appropriate time. We must instead stay focused on our mission. Whether on the traditional battlefield, or instead in the current COVID “battlefield” hospital environment, physicians, nurses, and allied medical support personnel have one job: to preserve life. It is on that focal point and no other that we must direct our full attention.

When the caseload becomes emotionally overwhelming, take a brief moment to step away and re-charge, and retain the lessons of medical care on the battlefield. Remember your training. Keep your head down and treat only the patient in front of you at the moment. Keep your focus. Do your job to the best of your ability, as you always have. And feel free to adopt the unofficial Marine Corps motto, “Improvise, Adapt, Overcome.” It serves as an invaluable touchstone in your practice at home, in a crisis here or abroad, and throughout all the myriad obstacles life invariably throws in our path. ■

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Ed. note: Dr. Zelk retired from military service in 2019 with the rank of Colonel after serving 23 years with both the Army National Guard and the Air National Guard.

Psychological Impact of PROTESTS

Anish Shah, MD

We are currently witnessing large-scale protests as a part of the Black Lives Matter movement. These protests are for a just cause and have been organized against racism and social disparities present in our society. Protests are an essential part of modern political life and play an important role in instigating social and political change. Some may also be accompanied by riots, with reasons for violence often being complex and varied. Much like the well-documented negative psychological impact of natural disasters and armed conflicts, recent studies have demonstrated a similar impact of collective actions such as protests and riots on mental health.¹

A meta-study involving data from 52 studies on protests and riots found that protests involving violence were, in the majority of cases, accompanied by negative effects on mental health.¹ The study showed an increase in the prevalence of symptoms of depression, anxiety, and post-traumatic stress disorder among the local population, regardless of their participation in the protests. Such effects on mental health were generally absent in the case of non-violent protests. However, two out of the 52 studies did show a positive impact of protests on psychological health, probably due to an increase in the sense of solidarity among the protesters.

The negative impact of such social unrest on mental health may be due to direct exposure to the events of the protest or the impact of protest on social life, employment, and other aspects of an individual's life.¹ Living, working, or attending

school near the location of a violent protest can increase the risk of depressive symptoms. Similarly, witnessing violence or being a victim of looting or physical violence is associated with an increased risk of PTSD. Besides such physical proximity to violence, other forms of connectedness or proximity to violence may also influence the degree of impact of violent protests on mental health.

A study conducted in Michigan following the fatal shooting of a Black man by the police found that other forms of proximity, such as emotional and personal connection to the events, disruption of daily life by protests, and experiencing fear after the protests, also influenced mental health.² For example, white participants were likelier to experience PTSD and depression if their lives were interrupted due to the events. On the other hand, members of the Black community, owing to their emotional and personal proximity to the events, experienced such adverse mental health symptoms, regardless of the disruption of their social life.

In addition to the factors directly associated with the events at the protests, other factors that may lead to depression or anxiety during or after protests include political uncertainty, a decline in employment opportunities, deterioration of social relations, and loss of employment. Increased exposure to news and images of violent protests through television or social media can also increase the chances of experiencing depressive symptoms. For example, during the 2019 Hong Kong protests against the extradition bill, higher use of social media was associated with an increased risk of PTSD, whereas a neutral stance toward political affairs was associated with a lower risk of PTSD.³ Social and demographic factors such as lower socioeconomic status, female gender, and younger age can also make individuals more prone to symptoms of



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on Mental Health and Coping

depression, anxiety, and PTSD as a result of exposure to violent protests. Besides the aforementioned effects, a multitude of factors, such as the nature of collective actions and the response elicited, may influence the impact of violent protests on mental health.

Most individuals participate in protests as an ethical act; they are unable to stand by silently in response to an actual or perceived injustice, despite the risk of physical or psychological harm. Individuals who fail to participate in protests often experience guilt, further supporting the ethical nature of such an act. Thus, it is almost impossible for individuals participating in protests to distance themselves from the traumatic events at the protests or the news about such occurrences at the protest. Furthermore, even individuals who do not or are unable to participate in protests are often emotionally invested in the protests. These individuals are likely to be exposed to the traumatic events of the protests through news or conversations.

Here are some strategies I recommend to help safeguard mental and physical health in the current climate:

1. Limit the consumption of social media and television news to reduce the impact of the protests on psychological well-being.

2. Do not engage in violent acts during protests. Violent protests are responsible for psychiatric issues not only in individuals involved in such acts, but also in bystanders to such violent events.

3. Avoid arguments with family members and friends. While family support can help to mitigate the negative effects of collective action on mental health, a major cause of depression during protests is the occurrence of interpersonal conflicts between family members and friends (or coworkers) regarding the politics of the events. Although a critical reflection of the stances one adopts is essential, individuals would be wise to avoid arguing.

4. Seek the company and support of like-minded individuals to avoid conflicts and have productive discussions. Such conversations can also help individuals to cope with traumatic events.

5. Limit discussions on political matters to no more than one hour a day and be respectful of the opinions of others.

6. Practice mindfulness through kindness and gratitude during this difficult time.

7. If possible, pledge to donate something to the most vulnerable individuals in our communities once a week. We are all distressed by repeated events related to racism and police brutality. In addition to these concerns, our community is also affected by long-standing disparities related to healthcare, employment and the economy. Although legislative changes are essential goals of these protests, small actions at the individual level, such as donating, can also help to make a difference.

8. Wear a mask and maintain social distancing at the protests. Close contact

with hundreds of protestors raises concerns about spreading the coronavirus infection, and a subsequent spike in COVID-19 cases that may lead to a second wave. It would thus be advisable to wear a mask at all times.

9. Do not protest at night. Violence has often erupted at night during the curfew hours; therefore, protesters should avoid venturing out during this time.

10. Focus on good nutrition and exercise during this challenging time. Besides improving physical health, diet and exercise are also useful in coping emotionally with the ongoing stressful events.

In the case of persistent symptoms of depression, anxiety, or PTSD, individuals should seek counseling. Individuals from minority communities may have negative attitudes toward seeking help for mental health problems. Promoting awareness in minority communities regarding the consequences of untreated mental health symptoms and the availability of mental health resources is important in making sure individuals get the help they need. ■

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References

1. Ni, Michael Y., Yoona Kim, Ian McDowell, Suki Wong, Hong Qiu, Irene O.L. Wong, Sandro Galea, and Gabriel M. Leung. "Mental health during and after protests, riots and revolutions: a systematic review." *Australian & New Zealand Journal of Psychiatry* 54, No.3 (2020): 232-243.
2. Galovski, Tara E., Zoe D. Peterson, Marin C. Beagley, David R. Strasshofer, Philip Held, and Thomas D. Fletcher. "Exposure to violence during Ferguson protests: mental health effects for law enforcement and community members." *Journal of Traumatic Stress* 29, No. 4 (2016): 283-292.
3. Ni, Michael Y., Xiaoxin I. Yao, Kathy S.M. Leung, Cynthia Yau, Candi M.C. Leung, Phyllis Lun, Francis P. Flores, Wing Chung Chang, Benjamin J. Cowling, and Gabriel M. Leung. "Depression and post-traumatic stress during major social unrest in Hong Kong: a 10-year prospective cohort study." *The Lancet* (2020).

Field Report: October 2019 Kincade Fire

Chad Krilich, MD, FAAFP

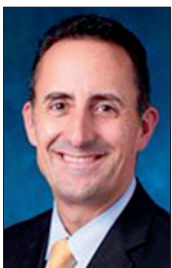
Management of hospital operations during a wildfire has become commonplace for caregivers in Sonoma County. This field report aims to compare the lessons from the 2017 Tubbs Fire¹ and more recent 2019 Kincade incident. The specific areas of opportunity to manage hospital operations include disaster preparedness, housing, capacity management, and caring for caregivers during a disaster. The aim of this report is to highlight operational interventions that can help other physician leaders who are faced with similar circumstances in the areas where they serve.

Problem and Significance

By way of history, St. Joseph Health, Sonoma County, is anchored by two core facilities: Santa Rosa Memorial Hospital (SRMH) and Petaluma Valley Hospital (PVH). SRMH is located off Highway 101, approximately 55 miles north of San Francisco. It is a 338-bed acute care hospital. It is the region's only Level 2 trauma center and serves Sonoma, Napa, Mendocino, and Lake counties. It opened its doors to the community in 1950 on New Year's Day and provides a broad array of services including a Level 3 neonatal intensive care unit, cardiac surgery, and neurosurgery. PVH is 40 miles north of San Francisco. It is an 80-bed general acute care hospital that provides services including a family birth center, general surgical services, and critical care.

October 2019 provided another wildfire experience for the residents of Sonoma County via the Kincade Fire. This fire in comparison to the Tubbs Fire in 2017 was less destructive to physical structures and human life, while it impacted more acres of vegetation (Table 1). The planned evacuations and planned power shutdowns did highlight operational challenges to two hospitals remaining open in Sonoma County. At its peak, the Sheriff's Office in Sonoma County reported that 180,000 residents of the county, nearly four in 10 people, were ordered to leave their home or business as a

precaution against the unpredictable spread of the Kincade Fire. In addition, the planned power shutdowns affected well over two million residents in 35 counties, according to Pacific Gas and Electric Company (PG&E) in Northern California.



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Operational Process

On Wednesday, Oct. 23, 2019, a vegetation fire northeast of Geyserville reportedly consumed 10,000 acres and destroyed two structures. Within the next two days air quality had worsened, Geyserville was ordered to evacuate, the affected acreage had doubled, and the number of structures had increased to 49. On Saturday, Oct. 26, at 1:27 p.m., Incident Command was opened at SRMH in accordance with the disaster preparedness process and a part of the hospital incident command system.

Immediately, roles were delegated and the objectives toward maintaining safety for caregivers and for normal hospital operations were established. Twice-daily briefings were held including reports from the public information officer, liaison, operations, planning, logistics, and finance. These efforts were coordinated with our partnering 80-bed facility in Petaluma; 208-bed facility in Napa; and the county emergency operations center. Practicing and following the process for the hospital incident command system was a critical part of the success in managing the Kincade Fire incident.

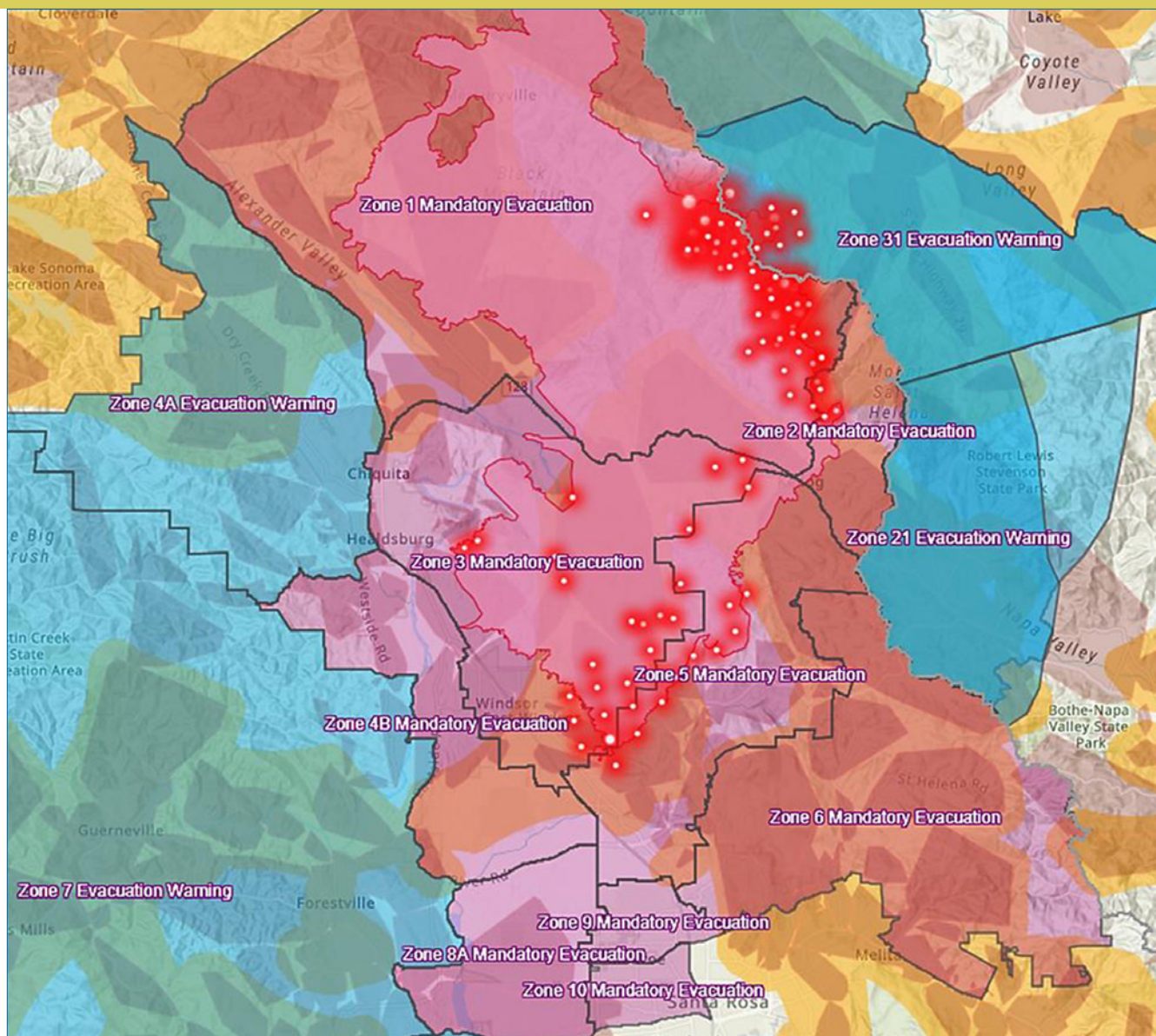
Disaster Preparedness

A lot of what was learned in 2017 prepared Sonoma County well for the Kincade Fire incident. Access was restricted to the Emergency Department (ED) and main lobby a day prior to opening incident command. The Tubbs Fire taught us that air quality in the hospital can be significantly impacted without these restrictions. Additionally, on the day incident command was opened, four air scrubbers were deployed and an additional 10 were delivered.

With a lack of primary care services because of the mandatory evacuations and planned power shutoff, caregivers experiencing respiratory symptoms had challenges while at,

Table 1: Comparison of the Tubbs and Kincade Fires

	Tubbs	Kincade
Acres	36,807	77,758
Days active	123	13
Structures damaged	317	60
Structures destroyed	5,636	374
Fatalities	22	—



Kincadee Fire impact map (www.fire.ca.gov).

or reporting to, work. A key tactic to help maintain a healthy workforce was to have caregivers report their symptoms to their leader or house supervisor. Thereafter, the hospital respiratory therapist would provide an assessment for treatment. If indicated, a call was placed to the pharmacy to initiate a standing order of medications for the caregiver. Maintaining good air quality and a safe environment were key objectives that allowed both SRMH and PVH to stay in operation.

The map extracted from the Cal Fire website during the incident provides some insight on the impact of the wildfire. The bright red dots represent active fire at its peak of activity. The evacuation areas are noted on the map. SRMH is located just above the "a" of the word "Santa" on the map. One difference from the 2017 event is the addition of the yellow and brown shaded areas, which note the locations of planned power shutoffs.

Over the course of 2019 PG&E had six planned power shutoffs. The shutoffs were performed in areas experiencing high wildfire risk with the goal of reducing the risk of power equipment and lines starting a fire. There were two shutdowns over the course of the Kincadee incident. The first was implemented the day incident command opened. In Sonoma County the shutdown impacted 86,713 customers and 2,721 medical baseline customers and lasted for three days. The second was smaller in scale and lasted two days, though it was implemented only days after the first power shutdown.

There were numerous impacts of the planned power shutoffs. Prior to the wildfires, it was not uncommon for our facility to receive patients requiring advanced imaging or elective surgery, given power resources were not operational at all outlying facilities during the power shutoffs occurring prior to the Kincadee Fire. In addition, the longer the

Table 2: Comparison of the Tubbs and Kincade Fires

	Tubbs	Kincade
Medical staff housing requests	68	6
Employee housing requests	79	32
Medical staff homes Lost	54	1
Employee homes lost	98	1

shutoffs persisted, the greater were the risks to patients that chronic conditions might be exacerbated. Resource centers were deployed throughout the entire North Bay to provide back-up power shelters. In discussions with community health workers, it was reported that some patients were staying in place even without back-up power for their concentrators or continuous positive airway pressure devices. This likely contributed to the capacity management challenges that both facilities faced. The mitigating strategy put in place at our facilities was to make power available for patients in our lobby and cafeteria, if necessary. If patients presented to the ED after the resource centers closed during the daytime, they were directed to either of these areas to meet their needs.

Along with impacts to our patients, our caregivers faced challenges as well. The general lack of power made it difficult, of course, to complete the typical activities of daily living. This included showering with cold water. More importantly for our caregivers was the lack of schools and childcare facilities open and in operation. During previous planned power shutoffs, a conference room was converted into a daycare area. The average number of children cared for was four per day prior to the Kincade Fire. During the Kincade Fire the average was nine, with a peak of 23 children cared for in one day. A dedicated space to care for our caregivers' children was key in maintaining normal operations.

Housing

While the 2019 Kincade Fire was not as destructive as the 2017 Tubbs Fire, the housing challenges it presented were quite similar given the power shutoffs and mandatory evacuations (Table 2). As previously mentioned, during the peak of the Kincade Fire, four in 10 people within the county were evacuated from their homes. The American Red Cross reported that 1,280 stayed in shelters overnight the day incident command was open at SRMH. One of the first tactics employed to maintain housing was to reserve hotel rooms for caregivers. Initial estimates were based on 10 percent of the workforce, given the impact of the Kincade Fire. This equated to 20 hotel rooms being reserved by the logistics section chief on the first day incident command was opened.

In addition to securing hotel rooms, the labor pool was created as a part of the hospital incident command system. Its role was not only to ensure the readiness and safety of our workforce; it also took in referrals for spare rooms or apartments for displaced caregivers. One of the last measures taken by the incident command was to secure a wing of the hospital that was offsite and not currently in use for a place to rest. Children and pets were not allowed. Again, caregivers were directed to the housing hotline for this resource.

Capacity Management

One of the overriding differences between the Tubbs and Kincade Fires was that when repopulation efforts commenced after the Kincade Fire, many residents still had homes to which they could return. This difference led to a significant surge in St. Joseph Health System facilities with the other two large health systems in Santa Rosa having undergone mandatory evacuations. Through appropriate planning both SRMH and PVH were able to maintain normal operations.



Incident command center team on the day that evacuations were lifted.

Table 3: Evacuated Healthcare Facilities in Sonoma County—Kincade Fire

	Pre-Fire Census	Discharged	Evacuated
Kaiser Permanente Santa Rosa Medical Center	127	17	110
Sutter Santa Rosa Regional Hospital	87	7	80
Healdsburg District Hospital	7	2	5
Apple Valley Post-Acute Rehab	92	6	86
Healdsburg Senior Living Community	24	2	22
Arbol Residences of Santa Rosa SNF	27	0	27
Healdsburg District Hospital SNF	16	0	16
Sonoma Specialty Hospital SNF	9	0	9
Totals	389	34	355

Santa Rosa Memorial Hospital

During the Kincade Fire in 2019, SRMH saw a patient surge when Geyserville was evacuated. Shortly thereafter, SRMH's transfer center limited its intake to only those patients needing advanced care for cardiac disease, trauma, obstetric, or pediatric care. If a clinical rationale existed to have the patient come to SRMH, the incident commander collaborated with key stakeholders to determine the best course for the patient under conditions present at the time.

There was a negligible elective surgery volume for the initial two days of the incident, given it started on a weekend. This allowed for the hospital to respond to the mandatory evacuations of nearby Kaiser and Sutter hospitals. Among the acute care and skilled nursing facilities, 355 patients evacuated (Table 3). SRMH had an influx of 23 patients: 12 patients went to the Women and Children's Unit; eight went to the Neonatal Intensive Care Unit; two went to the Intensive Care Unit; and one patient went to the Emergency Department. After accepting the initial surge of patients, the hospital itself needed to be prepared for evacuation, given the unpredictable nature of the wildfire.

With wind gusts up to 90 mph, the Kincade Fire threatened to inflict the same impact as the Tubbs Fire. On Sunday morning, incident command at SRMH received a request to evacuate. Upon seeking further clarification, it was determined that the mandatory evacuation would not include the hospital, as noted on the previous map. Driving the clarification was fact that the wildfire was greater than 10 miles from the facility and would need to travel through the previous Tubbs Fire area. The hospital incident command coordinated its briefings with the county emergency operations center over the course of the remainder of the incident to further ensure safety and optimize communication.

As the fire grew to 30,000 acres, with 10 percent containment and more than 79 structures destroyed, both elective surgeries and outpatient imaging services were cancelled. Leveraging the labor pool to utilize caregivers from Kaiser

and Sutter was another key in keeping our operations going. This was particularly important in the areas of the Emergency Department, and labor and delivery. Lastly, to improve patient flow, physicians in the Emergency Department created a call pool that enabled colleagues to see non-urgent patients in the waiting room. This proved to be critical following the repopulation of Sonoma County.

During this period two additional tactics were employed to provide additional support to the Emergency Department. On

several occasions during this period, the department saw 100 more patients than its average daily census of 120 (Table 4, p. 20). In order to meet this demand action was taken to have a flexibility request approved by the State of California Health and Human Services Agency. This request allowed the hospital's cardiac catheterization lab pre- and post-holding area the ability to accept patients in the afternoon—enabling a cohort of behavioral health patients to have a distinct place in which to receive care while SRMH was experiencing high volumes in the Emergency Department.

A not-so-successful tactic was putting our mobile van adjacent to the Emergency Department. The mobile van has two exam rooms and is routinely used to care for our homeless population. Signage was used to inform patients about their options of using the mobile van or the Emergency Department. Regulatory requirements such as EMTALA made it difficult to pivot patients from the waiting room to the mobile van in order to decant the facility. As a result, the mobile van only saw a handful of patients during the two days it was stationed onsite. Ultimately, as Kaiser and Sutter reopened, SRMH operations returned to normal volumes. The incident command was able to close 14 days after the Kincade Fire started.

Petaluma Valley Hospital

PVH's experience mirrored that of SRMH on the Emergency Department front. Many similar tactics around staffing were employed at both. Labor pools coordinated efforts to maintain higher than normal staffing levels to meet patient volumes. One aspect that was different in this event for PVH was that its inpatient census was double its normal volume. During the Tubbs Fire the census was higher, but the census never reached 50 in 2017. Over the course of the Kincade Fire it met or exceeded 50 on eight different occasions. The ability to meet this demand was based on the coordinated efforts around staffing and the overall resiliency of the caregivers.

Table 4: Santa Rosa Memorial Hospital Volumes Over the Course of the Kincadee Wildfire Incidents

Date	ED visits per day (Average = 120)	Left without being seen	Hospital Census (Average = 180)	Deliveries (Average = 1)	Comments
10/23/19	130	3%	207	2	Vegetation fire reported.
10/24/19	114	4%	222	3	16,000 acres
10/25/19	145	10.0%	221	1	Geyersville evacuated.
10/26/19	146	5%	209	1	1:27 pm incident start time. Healdsburg and Windsor evacuated. Planned power shutdown event.
10/27/19	158	3%	235	4	Kaiser and Sutter evacuated.
10/28/19	153	12%	224	1	Peak of wind event. Repopulation west of Santa Rosa.
10/29/19	180	2%	230	4	Additional planned power shutdown.
10/30/19	181	2%	224	4	
10/31/19	228	1%	222	4	60% of Kincadee Fire contained.
11/1/19	253	8%	220	8	PVH command center closed.
11/2/19	240	8%	233	7	Kaiser reopens.
11/3/19	180	0%	221	6	All community shelters closed.
11/4/19	168	2%	224	1	Sutter reopens.
11/5/19	144	1%	215	1	Incident closed 12:30.
Average	172.9	4%	221.9	3.4	

Caring for Caregivers

More than the above operational tactics that saw each facility through this disaster was the practice of caring for caregivers. I finished reading *Five Days at Memorial: Life and Death in a Storm-Ravaged Hospital* by Sheri Fink while writing this field report, and there is a lot to be said about communication. In the book, Charity's two hospital outcomes were compared to Memorial Medical Center during Hurricane Katrina in New Orleans. When members of the disaster mortuary team arrived at Memorial Medical Center, 45 bodies were recovered from the chapel, morgues, hallways, patient rooms, and Emergency Department. Charity Hospital had twice as many patients, with a lower ratio of staff to patients, but had fewer than 10 patient deaths. Here is what the hospital workers attributed to Charity's "resilience" in the face of this disaster:

1. Holding meetings every four hours with everyone from "doctors to janitorial staff," which included a talent-show by flashlight, painting, and laughter.
2. Category 3 hurricane drills, portable generators, oxygen-powered ventilators, and a ham radio system.
3. "Charity staff was populated by crusty characters accustomed to comparatively spartan, chaotic, and occasionally threatening conditions of an inner-city government hospital . . . Nearly everyone had experience getting creative with all-too-common resource limitations."

And my favorite:

4. "There was an active effort to stem rumors. You could only say it if you had seen it," staff were told."

There are many corollaries in how Charity and the St. Joseph Health Sonoma County hospitals operated. One tactic was specifically about meetings. Briefings were held at minimum twice daily. In addition, a key aspect of managing the incident was doing caregiver rounding. During these rounds, leadership would learn about key issues, whether lack of air scrubbers, staffing, or the need for information about evacuation. While rounding, each team was always armed with goodies such as donuts. Vicki White, our CNO, fondly referred to the power "Nutter Butter" cookies during a podcast hosted by one of our hospitalists, Dr. Mark Shapiro, about the Kincadee Fire.

Having had the Tubbs experience behind us, a similar tactic was deployed around financial remuneration for caregivers facing mandatory evacuations. Expenses were reimbursed for receipts that included hotel accommodations, kennel expenses, temporary grooming, hygiene, clothing, and meals related to travelling to new work locations. Also, if a facility or department was closed as a result of a mandatory fire evacuation and the leader was notified by the caregiver, and no other work was available, then the caregiver was made whole for lost work hours.

The incident lasted through the Halloween holiday. Historically, our ministries have held a costume contest. There was a discussion about whether to cancel the event considering everything that was occurring. While ours was not a talent show by flashlight like that which occurred at Charity Hospital, our costume contest went on as scheduled. The caution tape behind those pictured (see page 1, Table of Contents)

Table 5: Petaluma Valley Hospital Volumes over the Course of the Kincade Wildfire Incidents

Date	ED visits per day (Average = 50)	Left without being seen	Hospital Census (Average = 22)	Deliveries (Average = 1)	Comments
10/23/19	57	4%	42	2	Vegetation fire reported.
10/24/19	51	6%	42	1	16,000 acres
10/25/19	53	6%	38	2	Geyersville evacuated.
10/26/19	65	0%	47	1	1:27 pm incident start time. Healdsburg and Windsor evacuated. Planned power shutdown event.
10/27/19	93	8%	54	3	Kaiser and Sutter evacuated.
10/28/19	96	4%	57	3	Peak of wind event. Repopulation west of Santa Rosa.
10/29/19	96	3%	50		Additional planned power shutdown.
10/30/19	72	1%	46	1	
10/31/19	57	2%	50	4	60% of Kincade Fire contained.
11/1/19	69	1%	50	2	PVH command center closed.
11/2/19	78	4%	50	2	Kaiser reopens.
11/3/19	59	0%	50	5	All community shelters closed.
11/4/19	50	2%	50		Sutter reopens.
11/5/19	45	0%	46	1	Incident closed 12:30.
Average	67.2	3%	48.0	2.3	

was to prevent caregivers and families from using unauthorized exits. This tactic was employed as noted previously to maintain good air quality in the hospital, in addition to the use of air scrubbers. And the Halloween costume contest was a good boost to caregiver morale.

Lastly, some of our caregivers lamented the challenges of being open during this disaster. One of the rallying cries that came from our leaders was “Always Open.” This simple phrase helped to encourage our teams and build a sense of camaraderie. During one of the debriefings, the unit-based council for our nursing teams drafted a proposal for T-shirts. We look forward to sharing and being ready if we are fortunate enough to be operational during the next disaster.

Closing

The regularity of wildfires in northern California is becoming a normal experience in the fall. This field report emphasizes key tactics to put in place in acute-care facilities in the event of a disaster. They include ensuring safety for patients and caregivers whether it is a wildfire or planned power shutoff. Be forward thinking about the use of internal and external resources when housing is needed. This can include hotels, guest rooms, or unused patient care space. When it comes to capacity, management leans on the common things like modifying transfer practices and elective surgery scheduling.

Also, don't be afraid to try new things like leveraging spaces such as the catheterization lab or even trying a mobile van. And when caring for caregivers, have specific strategies

to understand what is going well, what is getting in the way, and just try to have fun in a difficult situation. This might enable the team—like our incident command group pictured on page 18—to come through better on the other side.

For a final thought, here is quote shared by a member of our medical staff during the Tubbs incident:

And once the storm is over, you won't remember how you made it through, how you managed to survive. And you may not even be sure, whether the storm is really over. But one thing is certain, when you come out of the storm, you won't be the same person who walked in. That is what the storm is all about.

—Haruki Murakami

Email: chad.krulich@stjoe.org

References

1. Krulich C., Currie, J. What Hospital Leaders Learned from the Wildfire. *Physician Leadership Journal*, Sept. 14, 2018.
2. California Department of Forestry and Fire Prevention. Tubbs Fire (Central LNU Complex). <https://www.fire.ca.gov/incidents/2017/10/8/tubbs-fire-central-lnu-complex/#incident-contacts>. California Department of Forestry and Fire Prevention. Kincade Fire. <https://www.fire.ca.gov/incidents/2019/10/23/kincade-fire/>.
3. Explore the Space. Vicki White on Holding the Line in a Disaster. <https://podcasts.apple.com/zw/podcast/vicki-white-on-holding-the-line-in-a-disaster/993287419?i=1000456223433>.

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Opioid Task Force Aims to Save Lives

Dave Anderson, MD

In 2014 several retired physicians in Healdsburg decided to perform blood-pressure tests around town, as we knew that many people were unaware of their status in this regard, and the fact that *hypertension* is called the “silent killer” because most patients are symptom-free.

The names of these doctors will be familiar to many: Ed Neal, Doug Pile, Rich Mucci, Damian Marsden, Hallie Beecham, Walt Maack, and me: Dave Anderson. We called ourselves the “Blood Pressure Squad” and visited service clubs, churches, health fairs, and various other places to perform tests. We did over 2,000 BPs and, as national data has shown, about 20 percent of those tested were significantly high. We encouraged all of these people to see their doctors for evaluation.

But our direction changed abruptly two years ago as something terrible happened in our small community. Three of our doctors lost sons to opioid overdoses. Bretta and Walt Maack were very open about their loss and shared a sincere and moving letter with the public via the *Press Democrat* (see page 24.)

So our BP Squad changed direction and became the Opioid Harm Reduction Task Force. We’ve accomplished much over the past two years, and are keenly aware that Healdsburg’s small-town

atmosphere and tight-knit medical community made our progress easier and faster.

With the leader-

Dr. Anderson is a retired internal medicine physician in Healdsburg.

ship of the local branch of the American Association of University Women (AAUW), a public educational forum was held at the Raven Performing Arts Theater, attended by well over 100 people. We spoke about the severity of the crisis, and how it affected families and the community. We emphasized that the opioid-dependent should be treated not as criminals, but rather as patients, and urged that treatment be made available to them locally.

We described Medically Assisted Treatment (MAT) and its effectiveness. We discussed Narcan (naloxone) nasal spray and encouraged people to obtain it in case of emergency if they knew a friend or family member suffering from opioid use disorder. We told them they are able to obtain Narcan at local pharmacies without a doctor’s prescription.

We also urged people to check their homes for opioid content, as one study has demonstrated that one in four teenagers have abused drugs from a home medicine cabinet. We also instructed them where and how to dispose of these drugs; in Healdsburg the police department has a private disposal location, and Healdsburg District Hospital has one in its emergency room. These steps were a big start, and I believe they had an impact on the community.

Shortly after that, I requested that Healdsburg Police Chief Kevin Burke arrange for Narcan nasal spray in all HPD vehicles. He took it on and within six weeks the department prevented an overdose death as a result. Over the last two years they have saved two more lives.

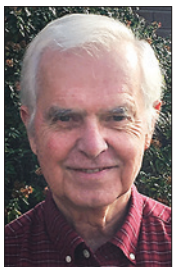
We also reached out to the Geyserville Fire Protection District to ask them to carry Narcan nasal spray as well as

EpiPens (epinephrine injectors) in their vehicles. The district covers not only Geyserville but Alexander Valley and Dry Creek Valley, a large area for which they are generally the first responders. They in turn worked with Cloverdale Fire to enable coverage all the way up to the northern border of Sonoma County.

Our Harm Reduction Task Force looked into educational courses that could be used in schools, and settled on a course called “Being Adept.” Thanks to a grant from the Healdsburg Rotary Club and help from the Alliance Medical Center, the course began in 2018 at Healdsburg High School. It was well received and has now been moved to the middle school. Alliance has also reached out to the Geyserville and Cloverdale school districts for the course to be taught there.

We have also tried to educate the people in our community about the dangers of fentanyl, which is 50 to 100 times more powerful than heroin, and has made its way to California. As little as 2 milligrams can be fatal to a person who has not developed a tolerance to opioids, and it can be absorbed through the skin—so it is dangerous even to EMTs who respond to an overdose emergency. One of the most dangerous uses of fentanyl is mixing it with other opioids, which can prove fatal. Fortunately, there are ways to detect the presence of fentanyl in a compound: fentanyl test strips. These test strips are available online and at Healdsburg District Hospital.

One of our ongoing concerns is the medical care for opioid-dependent people who become incarcerated and experience miserable



withdrawal symptoms in jail. We have been working with Sheriff Essick on this matter, as has the county health department. The sheriff and Wellpath, which holds the contract for medical care in the jails, are aware of these issues and working on solutions. Other communities are combining MAT with counseling and ensuring that MAT continues after prisoners are released.

Our group has also met with California Assemblymember Jim Wood, who is a Healdsburg resident and chairman

of the state health committee, to see if we can obtain state funding to facilitate MAT treatment in the prison system. We remain hopeful that will happen, thus removing the financial burden to the jails, and, most importantly, providing needed care for opioid-dependent prisoners.

Another issue is the availability of a sufficient number of physicians to prescribe MAT drugs such as Buprenorphine or Suboxone (buprenorphine/naloxone). The number of these physi-

cians is limited due to special training requirements. We have been meeting regularly with Alliance Medical Center, and they are making more providers available to the community. ■

What began as a terrible tragedy affecting three physician families in the Healdsburg area has developed into a program aimed at saving lives and preventing opioid use disorder. We have made great progress so far, and look forward to more in the future.

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LETTER TO THE COMMUNITY



Our 37-year-old son Morgan died of an accidental heroin overdose. He was an avid surfer who dodged big waves and sharks, but could not dodge addiction. We are devastated by his unexpected and untimely death.

Addiction is a family illness that not only had a huge impact on Morgan, but also on the rest of our family: unending worry, broken promises, shattered dreams, financial hardships, and disrupted relationships. We initially endured these agonies alone, feeling embarrassment about this unfairly stigmatized condition, but eventually found welcome and recommended support from Al Anon members and the Drug Abuse Alternative Center in Santa Rosa. Our family suffered mightily as we watched a sensitive and bright individual overcome by a relentless and cruel illness that ultimately took his life. Through the many difficult things we endured, our son suffered greatly, as well. Despite a year of being drug-free and making positive changes, in the end, addiction won. Now we are left with the difficult task of accepting the permanent loss of someone we love deeply.

We feel it is important to have compassion for addicts who often feel shame and guilt as they see the harm they are doing to themselves and others. However, this is not easy, because the disease frequently changes a person into someone with few redeeming qualities. Addiction is not a weakness or moral failing but a complicated disease with many facets, including brain chemistry, genetics, environmental factors, and trauma. It is difficult for those of us not addicted to understand the compulsion that drives addicts to use. Their need for drugs has been likened to the need for air.

Drug and alcohol abuse is epidemic in our country. The opiate epidemic is killing more than 150 people a day, and the numbers are rising. Overdoses are now the leading cause of death for those under 50.

Even though addiction touches many families, few people are well-informed. While Alcoholics Anonymous and Narcotics

Anonymous have been valuable programs for many addicts, a one-size-fits-all approach for treating addiction has failed others. Newer evidence-based treatment programs, including medical support/effective medications and addressing underlying mental health issues, will help more addicts find long-term recovery.

The Affordable Care Act mandates that substance abuse have parity with other medical conditions, but in the current political climate Affordable Care Act/MediCal reimbursements for treatment programs are in jeopardy. As it is, there is a severe shortage of treatment programs, and those that do exist are often prohibitively expensive.

Even as a physician and a nurse with some resources and knowledge of navigating the system, we often hit dead ends while trying to find support for our son.

For us, what is intensely personal has become political. The senseless death of our son brings home the horror of the nationwide opiate crisis. The “war on drugs” has not been effective, yet we persist in criminalizing drug use instead of treating it as a medical issue.

There is a model for the approach we could take. In the 1990s, 1 percent of Portugal’s population was addicted to heroin. In 2001, Portugal mostly decriminalized drug use and now provides mandatory treatment for addicts, resulting in a drastic decline in drug-related deaths. Portugal now has the second lowest overdose death rate of the 28-eight member European Union. And, it is far cheaper to treat those with addiction than to jail them.

A new approach may save other families from the heartbreaking pain and loss we are experiencing. Our son’s keen intellect, his kind heart and the love of his family could not save him. Perhaps a more enlightened attitude would have made a difference. It certainly wouldn’t have hurt. ■

—Dr. Walt Maack is a retired emergency room doctor who practiced in Healdsburg for nearly 40 years. Bretta Rambo is a retired nurse. They live in Healdsburg. Their letter was published in the Press Democrat in September 2017.

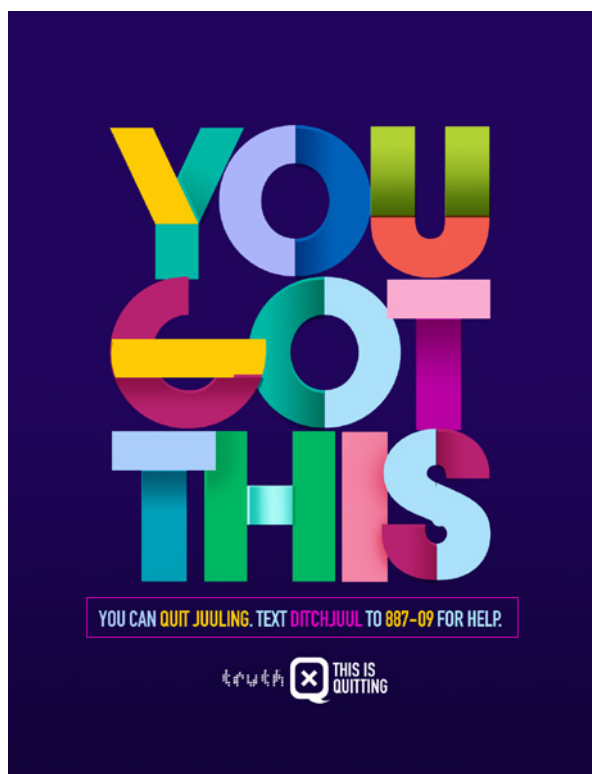
Sonoma County Battles YOUTH VAPING EPIDEMIC

Terese Voge and Ariel Thomas-Urlik

The phenomenon of youth vaping has been declared an epidemic at the federal level of the U.S. government. According to last year's National Youth Tobacco Survey, more than five million of our country's young people are using e-cigarettes, with fully 20 percent of those using such products on a daily basis.

While vaping can refer to the use of marijuana or nicotine, our focus is on nicotine vaping. The percentage of our young "vapers" far exceeds that of teen cigarette users. And, while e-cigarettes were initially marketed by industry as a healthier alternative to tobacco products, and there was hope within the medical community that there would be efficacy for cessation, the reality is that e-cigarettes expose users to a number of health threats. They have been linked to lung and heart diseases.

Terese Voge serves as health program manager for the Sonoma County Department of Health Services. Ariel Thomas-Urlik, MPH, is a program planning evaluation analyst.



Flyers like this one are available at thisisquitting.com.

They expose our youth to harmful substances, and research shows that youth who vape are four times as likely to begin using cigarettes. And they can place teenagers at risk for developing an addiction to nicotine.

Because of the alarming growth in the number of youth who are vaping, doubling since 2017 alone, school administrators once resorted to punitive measures that yielded mixed results. This is because of the stark reality that many students will continue to vape nicotine-based products even when facing penalties as serious as suspension, as the grips of addiction

are strong and real for many. Today things have progressed, and more schools are deploying restorative practices that both support students and acknowledge the propensity for nicotine dependence, and how it impacts behavior.

To combat this epidemic at the local level, Sonoma County's Department of Health Services' Impact Sonoma: Tobacco and Nicotine Prevention team has adjusted our work to respond to this crisis. We provide prevention services and coordinate tobacco/nicotine control activities with our community partners and allies to create a healthier community.

Under the Impact Sonoma program, we deploy cigarette-tax revenue to combat teen tobacco/nicotine use in numer-

ous ways. First, we are working with physicians across the county whose patient rosters include teenagers to provide screening for e-cig use. If a healthcare provider learns a patient is using these products, the provider can refer them to services that can be useful for both education on the dangers of e-cigs, and as well as treatment options.

We also work with our physician community to increase awareness of the unique symptoms and behaviors associated with teen vaping. These include nicotine addiction, mouth and throat irritation, coughing and

wheezing, worsening asthma, chest pain, raised blood pressure, raised heart rate, upset stomach and nausea, mood swings, anxiety, nicotine toxicity, and can exacerbate or be a catalyst for mental health conditions such as depression. Physician awareness of such symptoms in their teen patients can thereby increase the odds of a successful intervention.

A key element of these physician referrals is Impact Sonoma's "Quit Card." Participating physicians can keep a supply of these on hand to distribute to teens who vape, and the card lists services accessible to help users quit vaping or smoking. Participating resources listed include The Northern California Center for Well-Being; Petaluma's Nicotine Anonymous Support Group and the Petaluma Health Center; the California Smokers Helpline (800) NO-BUTTS and at (844) 8-NO-VAPE; Smokefree.gov, which features quit apps, self-help materials, texting, and an online chatroom; and thisisquitting.com,

an e-cigarette quitting program also featuring texting and online chat.

The success of our e-referrals for patients has been notable: fully 40 percent enroll in cessation-education classes, which have been proven to double the chances of quitting these products. E-referrals also provide a big assist to our healthcare providers, because the opportunity for the patient to talk later with "a regular person" about their use provides what is called a "warm handoff" from a doctor in a lab coat to a civilian, who might seem less intimidating.

This success is important for two critical reasons. Screening is beneficial to patients, because it connects them to educational resources, services, and treatment options about which they might not otherwise be aware. The other benefit is to the providers, as their awareness about substances their patients are using increases, and thus the potential for their patient rosters' overall health rises.

Beyond teen vaping, Impact Sonoma's

mission includes the ultimate goal of a tobacco-free Sonoma County. Toward that end we:

- Provide technical assistance resources to local governments, coalitions and individuals—seeking to strengthen protections for the public at large.
- Answer inquiries from the general public about tobacco concerns and the implementation of laws and policies related to tobacco and secondhand smoke.
- Provide guidance and support to schools and government jurisdictions looking to bolster prevention and compliance efforts.
- Serve as a tobacco prevention resource to our community.

All of these Impact Sonoma programs and services can be of great use to the SCMA physician community. While many healthcare providers may not wish to weigh in on matters of public policy regarding potential bans on e-cigarette products, they are still encouraged to contact us in order to voice their opinions on our programs. We encourage SCMA members interested in this topic to share their impressions by emailing us at preventioninfo@sonoma-county.org, or calling us at 707-565-6680. Impact Sonoma: Tobacco and Nicotine Prevention can also be reached via our Facebook and Instagram pages.

Once hoped to be a "the safe alternative to cigarettes," e-cigarettes are not smoking-cessation devices at all. In fact, most e-cigs impart greater amounts of nicotine than do traditional cigarettes. Impact Sonoma's motto sums up both our approach to the public health battle against nicotine-based products, as well as the reason for our continued success: "No judgement; just help. You haven't failed if you keep trying." A systems change approach, access to a broad array of resources, and a strong commitment to our goals together promise to yield positive outcomes, both in the immediate future and for the long term as well. ■

Emails: Terese.Voge@sonoma-county.org;
Ariel.ThomasUrlik@sonoma-county.org



Join Our Team in the Heart of Sonoma Wine Country

Healdsburg District Hospital is seeking a full-time Primary Care Physician with a background in Family Practice or Internal Medicine. This position would be located at our Healdsburg Physician Group Clinic on the hospital's campus located in the heart of Sonoma Wine Country. About an hour north of the Golden Gate Bridge, beautiful Healdsburg, California offers wonderful wineries, world-class dining, redwood forests and gorgeous countryside.

Healdsburg District Hospital connects and delivers personalized high quality, accessible local healthcare services, and advocates for the health and wellness of the communities in the District. Healdsburg Physician Group is a distinctive primary care group delivering the highest-quality care and service available, and offers providers gratifying and sustainable careers. As an outpatient department of a Critical Access Hospital and independent of large healthcare institutions, our clinic is open Monday – Friday, hours 9am – 5pm.

In addition, we offer benefits designed to aid your health and wellness including:

- Comprehensive Medical, Dental and Vision plans
- Robust voluntary insurance plan options
- Retirement Savings Program with Employer match
- Paid Time Off (PTO) starting at over 30 days per year
- Relocation assistance
- Malpractice Insurance coverage
- 5 days of Continuing Medical Education (CME) and \$5,000 CME reimbursement;
- Hospital sponsored loan repayment program and eligibility for additional loan programs

Our ideal physician will have:

- Excellent clinical and communication skills, bilingual ability a plus
- An interest in using technology to deliver high quality, primary care
- The desire to be an integral part of a rapidly growing team of clinicians dedicated to changing health care delivery
- BC/BE in Family or Internal Medicine
- California Medical license

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2020 ANNUAL SCMA CONTRIBUTION AWARDS CALL FOR NOMINATIONS

Good leaders influence and motivate others.

They have the confidence to stand alone, the courage to make tough decisions, and the compassion to listen to the needs of others. Do you know individual colleagues who demonstrate excellence and a strong commitment to improving our community?

SCMA is seeking nominations for the **2020 awards**, which honor individuals who have demonstrated exemplary service. The awards reflect a significant tribute of respect, recognition and appreciation from SCMA member physicians. Awards may also be given to nonphysicians and practice managers who have made significant contributions to the advancement of medical science, medical education or medical care. The awards are as follows:

#1 Outstanding Contribution to the Community

Presented to an SCMA member physician whose work has benefited the community.

#2 Outstanding Contribution to Local Medicine

Presented to an SCMA member physician who has improved local medical care.

#3 Outstanding Contribution to SCMA

Presented to an SCMA member physician who has served the medical association beyond the call of duty.

#4 Recognition of Achievement

Presented to an SCMA member physician or a nonphysician who has helped advance local medicine.

#5 Practice Manager of the Year

Presented to an SCMA member physician's practice manager who has provided exemplary support to staff and patients.

Physician candidates must be SCMA members and may be nominated for more than one award. If you are unsure if the physician you are nominating is a member, please submit your nomination and SCMA staff will confirm. *You do not have to be an SCMA member to nominate a colleague for an award.* **Nominations are due by Wednesday, Sept. 30.** For more information, call **707-525-4375** or email exec@scma.org.

Self-nominations are encouraged and accepted!



SCMA 2020 ANNUAL AWARDS NOMINATION FORM

Awards will be presented at the annual Gala dinner Wednesday, Dec. 9 at Vintner's Inn, Santa Rosa.

TO: SCMA 2020 Awards Committee

FROM _____ PHONE _____
(Name required)

NOMINEE _____ AWARD _____

For more than one nomination, submit separate forms for each. Please provide supporting information, including accomplishments and contributions that will help the Awards Committee evaluate your nominee.

Nominations must be received at SCMA by 5 p.m. on **Wednesday, Sept. 30.** Submit via any of the following methods:

Email to scma@scma.org | Fax to 707-525-4328
Mail to SCMA, 2312 Bethards Dr. #6, Santa Rosa, CA 95405

THREE DECADES OF AWARDS RECIPIENTS

	Outstanding Contribution to the Community	Outstanding Contribution to Sonoma County Medicine	Outstanding Contribution to SCMA	Special Award for Recognition of Achievement	Practice Manager of the Year
1990	Marshall Kubota, MD	Louis Menachof, MD	Ransom Turner, MD		
1991	William Ellison, MD	Harry Ackley, MD	James Clegg, MD		
1992	Harding Clegg, MD	John Reed, MD	L. Reed Walker Jr., MD		
1993	Tetsuro Fujii, MD				
1994	Thomas Honrath, MD	Lucius Button, MD			
1995	John Sweeney, MD	William Dunn, MD	Thomas Maloney, MD	Helen Rudee	
1996	Kenneth Howe, MD	Maurice Carlin, MD	Leonard Klay, MD		
		Winston Ekren, MD			
1996	Gary Johanson, MD	Michael Gospe, MD	Jerome Morgan, MD	Brother Toby	
	Harry Richardson, MD				
1997	Salute to Community Service	Salute to Community Service	Salute to Community Service		
1998	Gregory Rosa, MD	James McFadden, MD	Donald Van Giesen, MD	Daryl Schloss	
1999	Chris Kosakowski, MD	Mark DeMeo, MD	Clinton Lane, MD		
	Brian Schmidt, MD				
2000	Katherine Walker, MD	Frank Miraglia, MD	Cynthia Bailey, MD	Steve Osborn /Joan Chilton	
2001	Jeffrey Miller, MD	Robert Huntington, MD	William Meseroll, MD	Andrea Learned /Larry McLaughlin	
2002	Bob Schultz, MD	Louis Menachof, MD	Paul Marguglio, MD	Cynthia Melody /Harry Polley/ Assemblywoman Patricia Wiggins	
2003	Amy Shaw, MD	Brien Seeley, MD	Ron Van Roy, MD	Elizabeth Chicoine/ Cheryl Negrin-Rappaport	
2004	Michael Martin, MD	Jan Sonander, MD	Dan Lightfoot, MD	Sharon Keating	
2005	Richard Powers, MD	Mary Maddux-González, MD		Medicare Campaign Leaders	
2006	Rick Flinders, MD	Leigh Hall, MD	Lynn Mortensen, MD	Robert Pelligrini	
2007	Jose Morales, MD	James Gude, MD	Phyllis "Jackie" Senter, MD	Kay Reed & David Anderson, MD	
2009	Walt Mills, MD	Jeff Sugarman, MD	Brad Drexler, MD	Santa Rosa Family Medicine Residency Consortium	
2010	Stacey Kerr, MD	Lyman "Bo" Greaves, MD	Richard Andolsen, MD		
2011	Allan Bernstein, MD	Enrique González-Méndez, MD	Kirk Pappas, MD	Operation Access	
2012	Jeff Haney, MD	Mark Netherda, MD	Catherine Gutfreund, MD	Redwood Community Health Coalition	
2013	Robert B. Mims, MD	Peter Brett, MD	Walt Mills, MD	Northern California Center for Well-Being	
2014	Joe Clendenin, MD	Laurel Warner, MD	Ritch Addison, PhD		
		Charles Elboim, MD			
2015	Richard Powers, MD	Congressman Mike Thompson, Brad Drexler, MD/Len Klay, MD/ Jan Sonander, MD	Medical Review Advisory Committee	SCMA Alliance Foundation Holiday Greeting Card	
2016	Gary Barth, MD	Jerry Minkoff, MD	Rob Nied, MD	Partnership Health Plan of California	
2017	Allan Hill, MD	Lisa Ward, MD	Clinton Lane, MD	Steve Osborn/ Medical Heroes of the Firestorm	Kris Hartigan, RN
2018	Joshua Weil, MD	Ramzi Deeik, MD	Patricia May, MD	Judy Coffey, RN	Karen Weddle
2019	Shelleen Denno, MD	Andrea Rubinstein, MD	Peter Sybert, MD	Mary Szecsey	N. Jay Farris

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SCMA Awards Gala at Vintners Inn

Wednesday, Dec. 9, 2020

Watch for details in the monthly *News Briefs* e-newsletter.

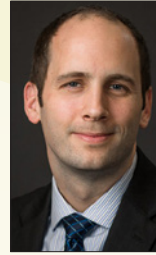
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COVID-19

- Hospitals, health centers adjust to a new reality
- The impact on small and solo practices
- Interview with Dr. Sundari Mase
- 1918 Spanish Flu in Sonoma County



Dan Peterson, CEO, Sutter Santa Rosa Regional Hospital

Adjusting our facility to respond to COVID-19 has been an incredibly costly and difficult endeavor that will significantly impact us for years to come.

Our entire integrated network acted quickly to adapt our “normal” operations and prepare for a surge of patients in response to this pandemic. While we have not yet seen a surge in patients, we remain ready to care for patients should a surge arise.

In preparation, we scaled down non-emergency patient care, limited surgeries, and shifted thousands of patients from in-person office visits to telemedicine visits. These decisions were made in alignment with local, state, and federal guidelines to support slowing the spread of the virus, and with the safety of our patients, employees, and clinicians as our top priority. Understandably, these changes have impacted patient volumes across the board.

Our inpatient levels significantly decreased in March and April and began to rebound in May and early June. Our emergency department census continues to climb. In March, our emergency department saw approximately 60 percent of its normal intake, and roughly 70 percent in April. We attribute this dip to those who are fearful of coming in because they think they will contract COVID-19. This is especially concerning because we are seeing patients who are prolonging timely care. Their condition has worsened, and now they’ve done lasting harm and require advanced treatment and care.

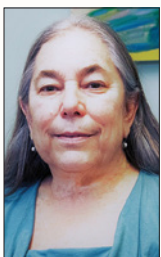
We are currently taking a phased, safety-first approach to gradually broaden our clinical services where local guidance and public health orders allow us to do so. As of early June, we were not running at the same level of efficiency as before, which impacts our census and ultimately, our business. For example, many of our patients coming in for outpatient services are met in the parking lot instead of in the waiting room; we allow for greater time between patient visits; and we use extra cleaning measures—all of which add time to each appointment.

We continue to focus on long-term planning and responsibly managing our day-to-day operations so we can best serve the community for years to come. While the impact of COVID-19 is unfortunate,

Local Hospitals, Community Health Centers Adjust to COVID-19 Reality

Dan Peterson, Donna Waldman, James Schuessler and Karen Milman, MD

and it's been tough to see the impact on our community, every decision we've made has aligned with our not-for-profit mission and values, and we are proud to care for all our patients here in Sonoma County.



Donna Waldman, Executive Director, Jewish Community Free Clinic

During the first week of the viral outbreak, which fell in the second week of

March 2020, we were understandably very busy at the Jewish Community Free Clinic (JCFC) in Santa Rosa. The overflow of patients made it difficult for us to initiate and enforce necessary safety precautions, in part because our facility is staffed by all-volunteer caregivers, with a new round of physicians and nurses arriving with every shift rotation.

By the third week of March we realized that the wise move would be to close down the clinic for a week, so that uniform safety, security, and hygiene protocols could be enacted. During this time we also took pains to inform and educate our clients and the public at large about the new policies and procedures under way at JCFC. At the end of March we were back to full staffing, and had "pivoted" largely to telemedicine and over-the-phone medical consultations

to ensure safety for both our caregivers and the patient population that takes advantage of our free services. At this writing we are seeing all of our patients either via video conferencing or speaking to them by phone.

Because the underserved are a large portion of our client base, and because this demographic contains a large percentage of low-wage workers serving in home-based, outreach, or long-term care facilities, free tuberculosis testing is in high demand at our clinic. Where we previously conducted in-clinic skin tests for this purpose, because of COVID-19 we switched to referrals for off-site blood tests, instead.

And we continue to fill prescriptions for our clients, albeit under social distancing protocols. Our office is fortunate in that we have an open-air, gated atrium near the entrance. When a patient arrives to pick up a prescription, we take advantage of the atrium to dispense the meds and provide any explanations regarding their use. There is a waiting area outside the gate that allows each patient to come forward, one at a time, to receive their prescription. Patient safety as well as the safety of our staff is our highest priority: fully 90 percent of our all-volunteer physician and RN caregiver contingent is over 65, and thus at higher risk from the virus.

Every day of the week we meet or coordinate with other health centers

across the county, so that all affected parties can receive up-to-date information, provide referrals, and in general continue our important collective mission. JCFC Medical Director Josh Weil, who has served us for over a decade, has been tireless in acting as our liaison with area hospitals and in helping the entire community better understand the social determinants of health. The stellar effort underlying this comprehensive education outreach is the reason why so many of us rightfully believe that when a healthcare emergency strikes, Sonoma County is the best and safest place one could possibly be.



James Schuessler, CEO, Healdsburg District Hospital

While I am somewhat new to Sonoma County, it took no time at all for

me to be impressed by the healthcare professionals not just here at Healdsburg District Hospital (HDH), but across the entire North Bay region. This is a most impressive medical community, with very high quality clinical professionals exhibiting a positive approach and outlook amid what has been a great challenge in the onset of COVID-19.

This includes county public health director Dr. Sundari Mase, who has



shown prudent judgment and great sensitivity at a particularly difficult juncture. We have worked cooperatively with Dr. Mase's department to carry out virus screenings here at the hospital, and in June we conducted a one-day event in conjunction with the department to screen 200 members of the Latinx community. Everyone here at the Healdsburg facility looks forward to working hand-in-hand with public health to overcome new healthcare obstacles, whenever and wherever they may arise going forward.

At the same time, our operation is joined by countless others, nation- and worldwide, in suffering some of the side effects brought on by the virus and associated shelter-in-place directives. Because so many elective medical procedures were deferred as viral infections grew, for a time we had no choice but to furlough some of our staff, as well as put others on reduced work schedules. However, as summer progresses and restrictions are lifted, we are experiencing a measurable rise in patient visits to our hospital as our ability to begin performing elective procedures has expanded. And we continue to explore potential cooperative business relationships with our brother and sister providers in an effort to ensure HDH's long-term financial strength and ability to serve this wonderful, scenic community.

Our protocols for cleanliness and patient health and safety are second to none. Some have remarked that Healdsburg District Hospital is "the safest place in Sonoma County." We'll take the high praise while also reminding the community—we are happy to be here, we are open for business, and our dedication to the healthcare needs of our citizens is stronger than ever before.



**Karen Milman, CEO,
Redwood Community
Health Coalition**

Redwood Community Health Coalition (RCHC) is a member network of 16 community health centers and a wellness center

with a total of 73 sites across Marin, Napa, Sonoma, and Yolo counties. Starting in February, we began closely tracking the Coronavirus outbreak and started conversations about what preparation would be needed. When cases began increasing in the Bay Area, our more formal response efforts launched both to prepare for a potential increase in patients presenting with respiratory illness, and to ensure all our patients would be able to safely receive the care they need. Telehealth, a concept we had already been developing to address access to care issues, became an immediate focus.

Over the past few months, we've reviewed all aspects of our operations, from morning "huddles," to how a patient moves through the building, to personal protective equipment, to how we clean and manage patient rooms. We've implemented measures to improve patient and staff safety. We shifted many visits to telehealth: video and phone. At the peak of shelter-in-place orders, 70 percent of our visits were remote. We are now in the process of expanding in-person patient visits. We've spent a lot of time determining which patients are best served with an in-person visit and which ones are better served with a remote visit.

When a patient calls for an appointment, we have a screening process to determine the best method to address their needs. Many appointments are now divided into two parts. The first portion is a telehealth/telephone consultation to get the patient's history and discuss the issues. The second portion of the visit is for the physical exam and to address next steps in treatment. All patients are screened for COVID symptoms or exposure prior to their visit. We've also shifted so that some aspects of medical care can occur in the patient's car, such as a receiving vaccine or collecting a specimen for a COVID test. Everyone who enters the building is screened for symptoms and their temperature is taken before entering. We require masks for patients and staff when they enter the building. Inside we ensure social distancing and try

to minimize unnecessary time in the facility. Creativity and innovation have been essential to keeping our critical operations fully functional.

Again, our goal is to ensure that patients who need medical care receive the care that they need. While we have shifted much of our patient visits to be remote, we encourage those patients who need to be seen in-person to come in. We have worked to ensure their safety. We do not want patients to defer care and risk worsening their health out of fear. We also want to be sure that individuals who have lost their health insurance and who need medical care know that our health centers are open to them.

Our health centers have also been collaborating closely with our county health departments. We have regular communications to share information on the evolving pandemic, to stay up-to-date on emerging guidance, and to coordinate community-level activities that go beyond our usual operations. Health centers have worked to expand access to coronavirus testing for our patients and their contacts. Several health centers are also coordinating with their respective counties on outreach to specific populations and plans for alternative care and sheltering locations.

As our scientific knowledge of SARS-CoV-2 and the local experience of the pandemic evolve, everything is continually being evaluated and adjusted. I would like to emphasize to all that this is a long-term response: some of the economy may have reopened, but we are still in the first wave of the pandemic. The health impacts of both COVID-19 and the economic changes will be ongoing and will be felt for quite some time to come. RCHC and our member health centers are well-positioned to tackle the challenges that are ahead. This is not a sprint, but rather a marathon, and we remain confident that we will continue to be here to serve throughout the course of the health emergency, and well beyond. ■

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Small and Solo Practices: Fewer Patients, Frightened Seniors, and Time to Reflect

Robert Schulman, MD, Yong Liu, MD, and Jeff Sugarman, MD



Dr. Schulman

I chose to view the springtime “lockdown” in as positive light as possible. Rather than focusing on the stress and negativity associated with

the slowdown in my practice, I tried to use the available time proactively, to study. I focused on musculoskeletal (MSK) ultrasound. MSK ultrasound facilitates a non-invasive, real-time window into ligaments, tendons, muscles, and joints—permitting diagnosis and treatment of trapped nerves, tears of muscles and tendons, arthritis, and other conditions.

In contrast to some of my other physician colleagues, I closed my office almost entirely for the duration of the shelter-in-place directive. This is because in my type of practice—physical medicine—it is typical to be able to see a patient in person and perform a musculoskeletal exam or functional assessment. I did see a few patients via telemedicine for integrative medicine consults and follow-up visits. While the shutdown proved to be a substantial financial burden for solo practices such as mine, it also afforded us the opportunity to reflect on important questions about the future.

One such question is: “What will

our practices look like going forward?” Similar to other offices, we will perform a COVID-19 screening on the telephone the day prior to the patient’s visit. Anyone entering the office, including family or friends accompanying the patient, will have their temperature and pulse oximetry obtained and recorded. Anything touched by a patient will be sprayed with alcohol. The bathroom will be sprayed after being used by anyone, including staff. Open boxes of tissues have been replaced with individual packets. And so on. We will change in and out of work scrubs in the office, and wear a gown over the scrubs. Since there is a shortage of gowns, we will label and then store for one week in the closet until they will be used again. Masks, of course, will be worn at all times, and instead of being discarded, they will be stored and used once again the following week. However, if an injection procedure is performed, a fresh mask will always be used. Gloves will be worn any time a patient will be touched.

Other protocols will be also be implemented, and we will ensure that these steps are communicated plainly to our patients via our website and in person. Hopefully this will give patients confidence such that they can once again seek out treatment, secure in the knowledge that their safety is our first priority.

I think we all hope that the recent slowdown of elective medical care is

behind us. For me, the shelter-in-place drove home the lesson that we don’t always have as much control of situations as we would like, and as medical professionals we are trained to try to make the best of all circumstances, no matter how difficult. When we pause and reflect for a moment, we realize how precious and fragile our health and life truly are.

Another question I’ve been thinking a lot about is the big picture in healthcare. So many Americans remain under- and uninsured. Professionally, I’m in favor of single payer as a solution to this problem. I view healthcare as a basic human right. At the time this article goes to press we have tremendous unemployment in our country. For many people insurance is tied to employment, and this creates a great sense of insecurity. I don’t think that corporations such as venture capital or private equity firms ought to profit from healthcare. I’m acutely aware that this is a complex issue and that many physicians may have other points of view.

I encourage all members of SCMA to become as involved as possible in our organization in any way they can. Please write articles for *Sonoma Medicine*, join committees, and email us your questions and concerns. Let us know how we can help improve your medical practices and job satisfaction as physicians and community leaders.

**Dr. Liu**

Mine is what some might refer to as a “mature” practice, as a fair percentage of my patients are seniors. And our senior

demographic in the United States has been hit particularly hard by COVID-19, both in terms of the numbers of seniors who have fallen ill, and also by the psychological effects—not just of the virus itself, but of the media’s somewhat sensationalistic coverage of it.

In spring 2020 a majority of my senior patients were paralyzed by fear and reluctant to leave their homes, for any reason. With 24/7 cable TV news virus coverage during the second quarter of 2020, many of these patients skipped their regularly scheduled visits to my practice, and also those to specialists’ offices for management of their chronic medical conditions such as high blood pressure, heart disease, and diabetes. Some were too fearful to visit the pharmacy for refills of essential medicines if home delivery was not offered.

To help ameliorate these factors and keep these patients under care, for several weeks this spring and early summer I used telemedicine, specifically phone consultations, to maintain contact with them. The main focus was an emphasis on medical needs requiring immediate attention and setting aside for the moment those of a secondary nature. In this case we see once again the special nature of the senior demographic: most of these folks are unfamiliar with the more timely technologies such as Zoom video conferencing or even Apple’s Facetime app, which leaves practitioners like me to employ the old-fashioned telephone call to keep in touch.

My patient visits from March through May, including in-office and telemedicine consults, were at about half of normal levels. While that has improved, many of these seniors won’t feel a sense of ease until testing becomes ubiquitous and

they have a high degree of certainty that medical office environments are virus-free. With the advent of drive-through testing stations here in the North Bay, my hope is that we will soon be able to achieve that goal. And as we look to the future with fingers crossed and prayers aloft, we collectively hope to avoid what has been called a “second wave” of the virus later this year.

**Dr. Sugarman**

Patient visits to our offices declined sharply, and understandably, right after the shelter-in-place directives went into effect in March. At

the height of the lockdown we were at about 10 to 20 percent of normal capacity, seeing urgent cases only, which included melanoma surgeries and skin eruptions, including possible skin manifestations resulting from COVID-19. We ramped up teledermatology using Zoom.

At the time of this writing in June we have completely opened, and are back to about 80 percent of what would be a full, normal schedule of patients, albeit with a few important changes in place. We have employed social distancing protocols starting at the time patients arrive at our parking lot. Upon entering the lot each patient’s temperature is taken, and each is asked questions about any pressing health issues that might be COVID-related. They check in at curbside and are assigned a number according to their place in the assigned order of appointments for that day. When the time comes for the next patient’s office visit, one of our staff accompanies that person from the car directly into the exam room, bypassing the waiting room altogether.

All cleaning and hygiene protocols in place at other healthcare facilities are also in practice here, including PPE, masks, scrubs, scrub hats, gowns, and face shields. The on-site washing machines are seeing full use as a result. And the curbside check-in procedures

outlined above have compelled us to be both creative and flexible with the best use of our staff: our full support staff is still needed to assist three providers, as opposed to the usual five physicians who would be on-site on a “normal,” pre-COVID workday, to make social distancing easier.

Our practice considers itself fortunate to have emerged out of the pandemic intact, at least for now. For obvious reasons, our providers and staff will continue with strict adherence to all distancing, cleaning, and hygiene protocols for the foreseeable future. The very last thing anyone wants to see is a renewed escalation in hospitalizations from a virus that has already exacted a painful toll on our region, the country, and the world. But I remain optimistic, and remind my patients as well as all our healthcare colleagues—we will get through this, stronger than ever before. ■

Dr. Schulman specializes in physical medicine and rehabilitation and pain medicine, with added qualifications in headache management, regenerative medicine, integrative medicine and medical acupuncture. Dr. Liu practices internal medicine. Dr. Sugarman specializes in dermatology and pediatric dermatology.

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Sonoma County Health Officer Sundari Mase, MD

Interview by *Sonoma Medicine Staff*

Ed. Note: Dr. Sundari Mase's tenure as health officer for the county began in March of this year, during the height of the health emergency caused by the coronavirus outbreak. Sonoma Medicine recently had the opportunity to speak with Dr. Mase about the challenges she has faced amidst an unprecedented viral pandemic.

You entered service in our community under unusual circumstances. What have been your biggest challenges?

I actually looked forward to being of service for the COVID-19 response because my entire career so far has been devoted to issues such as this. My experience and epidemiological background have been of great use in facing this challenging environment. Overall I've tried to maintain a balanced approach, weighing health expectations, political concerns, and the economic hardships that have beset our community since the onset of the virus. The depression, the anxiety, the need for our citizens to be able to feed and house themselves—these are all factors that must be considered when undertaking these tough decisions.



Do you anticipate future “shelter in place” orders if cases spike after the initial reopening?

Because our general health situation has greatly improved, and proper corrective measures have largely been put in place, I don't at this time anticipate the need for this. Thanks to our monitoring and modeling tools, and the ability to employ intense contact tracing, we can see where new outbreaks might be taking hold, and respond to them in a targeted way rather than in a “blanket” fashion.

What advice would you give to our small and solo practice physicians?

Follow the mitigation procedures provided by our office, by the state, and by leadership at the federal level. Employ masks, gloves, and social distancing in your practice, complemented by thorough cleanliness and personal-hygiene protocols. Use employee screening, including temperature readings, and keep detailed lists of your patient visits in the event contact-tracing follow-up is needed later.

Was there an actual PPE shortage in the county, or was that instead based on fear and/or media hype? How do you see our PPE supply for the long term?

Yes, there absolutely was a PPE shortage. N95 masks, respirators, gowns, gloves, face shields, swabs—all were in very short supply, and our office, like many others nationwide, initially had to order these supplies via purchases from Amazon and other outlets.

Today, however, we are in a good place in terms of PPE in stock, and don't foresee a shortage in our region any time



soon. To ensure that remains the case going forward, we continue to urge our citizenry to avoid ordering excess N95 masks for their own use, in the event that our frontline healthcare workers might need them in a future outbreak.

Seven health officers in this state have resigned amid the pressure and controversy surrounding stay-at-home orders. Do you feel supported by this community and its government leaders?

Political and law-enforcement leadership in Sonoma County has been very supportive, in general. Our mayor, Board of Supervisors, the police and sheriff's departments—they have been rock-solid, across the board. Our office has also received many letters, emails, and even flower deliveries from a grateful public that has been most generous and appreciative of the tough decisions we've had to make. Inevitably in trying times such as this there is a vocal

minority that has stood in opposition—and I completely understand. A thick skin is a requirement for a job such as this, and fortunately, I am blessed to have one.

How do you see Sonoma County's future if and when a vaccine might be developed?

While the arrival of a vaccine would be a wonderful development, there is of course no guarantee one will be identified—and further, no guarantee that a second vaccine might need to be created at a later time to combat future virus variants that might develop. The clearest message we can deliver for now is that we will all be living with COVID for quite some time, and to remain vigilant in response. An optimal and realistic hope is that we can at some point achieve herd immunity, once and for all.

How can SCMA best support you in the future?

I look forward to the day when I can spend more time getting to better know the leadership, staff, and individual members of SCMA. Because of developments in the second quarter of this year, that time has been very limited so far. But even so, I've had the pleasure of getting to know SCMA President Dr. Rajesh Ranadive quite well, and appreciate very much the feedback and guidance he has consistently provided me and this office throughout the COVID process—from the initial outbreak all the way to today, where we hopefully find ourselves winding down somewhat. I do understand that SCMA is very well managed, and has an active and forward-looking roster of members—always very positive signs for any medical association. ■

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The Spanish Flu in Sonoma County, 1918

By Louie Zweig

— Reprinted from the fall 2009 issue of *Sonoma Medicine* —

Spanish influenza did not originate in Spain. Instead, it probably began in Haskell County, Kansas, in the early months of 1918.¹ From Kansas, it traveled to Europe with American soldiers on their way to World War I. The virus multiplied in the trenches of France, and then, as soldiers came home or were sent to military hospitals, the disease spread to civilian populations, eventually killing more than 20 million people around the world.²

Those who died were often young and otherwise healthy. They died of cytokine storms, during which their immune systems sent massive amounts of white blood cells and fluids into their lungs.³ It was cruelly ironic: those with the strongest immune systems perished because of their overwhelming response to the disease. When the disease finally subsided in 1919, it had killed more people than had perished on both sides during World War I.⁴

The residents of Sonoma County knew about Spanish flu long before it arrived on Oct. 14, 1918. Several weeks before the first Santa Rosa case, the *Press Democrat* ran stories about the malady striking in other parts of the country. The disease made its first appearance on the West Coast on Oct. 9, landing in Camp Lewis, Washington, "with the

arrival of 217 officers and men of the 213th Engineer Regiment from Forest, Georgia."⁵

The flu reached Sonoma County within a week of the Camp Lewis outbreak. The county's first victims were people who lived in close proximity to each other. They included men working "in the State highway camp

As citizens began to
search more desper-
ately for a cure, they
turned to Fong & Lee
Chinese Herb Co.

on the Cotati boulevard" and children at the Lytton Springs Orphanage, who were bedridden by Oct. 15.⁶ The victims were similar to those dying across the country and around the world. The young and seemingly healthy died more frequently from the disease than did the very young or very old.

On Oct. 19, the *Press Democrat* published two obituaries for victims

of the Spanish flu. Walter Reiman, who had enlisted in the Navy, succumbed "after a brief illness with influenza," and Edith Olin, who had "a position with Proctor Bros., where she made herself indispensable to her employers," died a few hours later.⁷ The deaths came "as a great surprise and shock to all" and were quite tragic because the two were engaged to be married.

The *Press Democrat* published hundreds of such obituaries during the last months of 1918. Most of the dead were young: those starting careers or joining the military.

With the exception of a few warnings from the Surgeon General and some expressions of concern by President Wilson about the condition of soldiers in camps stricken by the malady, the executive branch did little to confront challenges caused by the pandemic. In *Influenza 1918*, Lynette Izzoni comments on President Wilson's neglect of the disease that ravished his nation:

He made no attempt to mobilize national or global consciousness to fight the microbe's legions. Wilson was busy fighting a war with visible enemies. It did not take a medical man to know that in his contest with the pandemic man's weapons were hopelessly crude. In the war against Spanish influenza, men were profoundly, disturbingly impotent.⁸

Mr. Zweig was a senior at Maria Carrillo High School when he wrote this article, which was adapted from a U.S. History class term paper.

While the executive branch may have turned a blind eye toward the Spanish flu, the military began offering advice early. In an article published in the *Press Democrat* on Oct. 9, Commodore J. J. Fitzgerald advised readers to “avoid crowded assemblages” and “avoid traveling on congested public conveyances.”⁹

The military was not the only public entity to fear the pandemic. Local officials knew what the flu could do, and they acted accordingly. In Santa Rosa, the schools were closed for as long as seemed “advisable,” as were local theaters and “the usual Saturday night dances.”¹⁰ The City Board took even more drastic actions in the face of emergency. In mid-October, it “prohibited public assemblages,” even though there would be an election in a few weeks with ballot initiatives dealing with banning alcohol, an issue vital to the economic survival of the county.¹⁰ This action usurped First Amendment rights, but residents of Santa Rosa seemed more concerned with their safety than their rights.

District Attorney George Hoyle was thought to be a reputable authority on Spanish flu. On multiple occasions, he offered advice in the *Press Democrat*. On Oct. 31, for example, he suggested that “rushing to country resorts . . . should be stopped at once as many of them [are built] in cool, damp places . . . which must necessarily endanger them to cold, and frequently to resulting pneumonia.”¹¹ Later, on Oct. 31, he wrote, “the health authorities declare the epidemic will not be brought under control until the public generally takes to wearing gauze masks.”¹²

While the public had little trouble ceding their constitutional rights, wearing gauze masks was apparently another story. At first, local officials merely suggested that community

members don the masks. Their notices to the public were usually accompanied by advertisements for masks by the “dependable” Luttrell Drug Company. Neither the suggestions nor the advertisements seemed to have much effect, for the suggestions continued over the next few weeks, each time with stronger language. Eventually, the Santa Rosa Board of Health compelled everyone “to wear masks in public.”¹³

This edict was largely ignored, and after a few days, County Health Officer F.O. Pryor wrote, “There seems

company published a notice in the Oct. 27 *Press Democrat* explaining that the epidemic had not only “greatly reduced our operating forces,” but also “caused a tremendous increase in the volume of local telephone calls.”¹⁷ They concluded by asking customers to “reduce their use of the Telephone.”

Even though Spanish flu devastated Sonoma County, businessmen were quick to use it to their advantage. Dibble’s, a clothing store in Santa Rosa, ran an ad in the *Press Democrat* from October to January, boasting about

the store’s safety. They assured their customers that “this shop has taken every precaution possible. Proof is—not one of our salesladies have been ill.”¹⁸ Not to be outdone, local lingerie seller Frank Looms ran an ad stating that, “Pessimism is a friend of the Hun and the flu. Optimism makes life better. We are firm believers in optimism.”¹⁹

Other businessmen capitalized on the hope for a cure. W.E. Rutherford sold Cactus Brand Antiseptic Solution at his “Quality Drug Store,” promising

customers, “with this precaution you are quite safe against contagion.”²⁰ Likewise, when local officials required residents to wear masks, Luttrell Drug Co. immediately sent an ad to the *Press Democrat* informing Sonoma County that the store carried masks “made of four thicknesses of sterilized gauze, and large enough to cover the nose and mouth.”²¹ Luttrell sought to gain the upper hand on competitors by hiring “two extra boys for quick delivery service.” As citizens began to search more desperately for a cure, they turned to Fong & Lee Chinese Herb Co., whose ad boasted “hundreds of sufferers [cured] who were pronounced incurable by other physicians.”⁴ Even in the face of pandemic, the American mercantile spirit shone through.



Staff wearing gauze masks at the McNear Feed Mill in Petaluma.

to be considerable misunderstanding concerning the county mask ordinance.”¹⁴ He notified officers to make arrests and impose a \$25 fine on those who ignored this law. As a result, “a number of people were arrested and were compelled to decorate the mahogany with fivedollar pieces in the recorder’s court.”¹⁵

When people began avoiding crowds, many businesses in Santa Rosa suffered. Sweet’s Santa Rosa Business College, for instance, closed for at least a week, “on account of the prevailing epidemic.”¹⁶ Even more profound were the flu’s effects on the Pacific Telephone & Telegraph Co., which held a virtual monopoly over telecommunications in Santa Rosa. The

Because Santa Rosa and its surroundings were predominantly rural, its medical resources were not capable of dealing with a full-fledged epidemic. Red Cross nurses were overworked. They made "a strong appeal for patriotic women [to] volunteer their services to enter homes where mother and housekeeper [are] down with influenza, to care for the family and sick."²² As the number of patients increased, the number of able nurses dwindled, creating a desperate situation in which the sick had seemingly nowhere to turn. One of them was Francis Little, who was 10 years old when she came down with the Spanish flu in early 1919. In a 1989 letter to local historian Gaye LeBaron, she recalled her mother's attempts at finding a nurse to care for her:

When she tried to get a nurse she took a cab to Sebastopol to see if Ruth Burns [was available]. She was busy—then Rose Donnelly and when she went up on the porch—there were three bodies waiting to be picked up. So it was a tragedy.²³

Pharmacists were in almost as high a demand as nurses. Traveling druggists were "called in by their houses on account of the tremendous run and orders which have swamped the houses. This is owing to the influenza epidemic."²⁴ Even with extra workers, the pharmacies could not handle the number of calls the pandemic produced. They appealed to the public in the *Press Democrat* on Oct. 22: "The houses don't want more orders just now as they cannot handle those on hand."²⁴

Santa Rosa citizens were just as generous as their medical workers were stressed. Red Cross officials asked in newspaper columns, "Can you cook a custard or make a glass of eggnog?"²⁴ The community responded:

Hotels and restaurants provided hot meals. Butcher Paul Noonan donated 25 pounds of soup meat everyday. Wildwood Dairy brought three gallons of fresh milk to the Red Cross every afternoon. Farmers

stopped by with live chickens to make broth or a bushel basket of potatoes.⁴

While Sonoma County's generosity shone throughout the epidemic, the response to the crisis at the Lytton Springs Orphanage was particularly remarkable. The children at the orphanage lived in close quarters and shared all facilities. As a result, influenza spread easily throughout the population. In mid-October, Captain Isaacs, who ran the orphanage, reported that there were

the epidemic in that institution was \$300.03.²⁷

The pandemic had adverse psychological effects; there was pervasive fear throughout the community. When people went to visit friends, they didn't go into houses where they "saw that someone was sick."²⁸ Boarding schools, where children slept in close proximity, became places of high anxiety. At Ursuline College, the doctor "ordered the school closed and told the Sisters to send the boarders home."²³ Even after the schools opened, the fear did not diminish. A young woman named Jean wrote in a letter to her mother, "the school opened last Monday the children and teachers wearing masks but they had a very poor attendance so they closed again."²⁸

In that same letter, Jean expressed the hope that "it [would] be just a little while and the flu [would] be checked it seems it [had] to take its course." She was confident that "things [would] go like good old times." Then she moved on to her plans for supper and to a recipe for corn bread, describing it as "a peach." Life went on.

Jean was not alone in her optimism. Right next to a story about the flu in the Nov. 7 *Press Democrat* was an article headlined "Deer Lassoed and Caught in Rincon Valley." While the press reported on the steady stream of death in Sonoma County, they continued to run stories about the "most exciting things that . . . happened . . . in the sporting circle."²⁹ The juxtaposition of humorous articles with grim obituaries suggests that Santa Rosans were not consumed by panic. Survivors continued to live their lives.

Just as Sonoma County residents heard about the pandemic before experiencing it, the news of the waning of influenza reached the county before the disease actually subsided. On Oct. 23, the *Press Democrat* published an article stating that, "improvement of the influenza situation in army camps and in a number of states were shown

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Please advise all members of your family and your friends of the critical situation now facing the COMPANY and the PUBLIC and URGE them to REDUCE their use of the Telephone.

The PACIFIC TELEPHONE & TELEGRAPH CO.

Notice in the Press Democrat, Oct. 27, 1918.

more than 150 cases at the orphanage. "We are doing the best we can," he said in a *Press Democrat* article, "and from the bottom of our hearts we thank the generous-hearted people who have responded to our call."²⁵

After the appearance of the newspaper article, the orphanage collected a "sum of \$60.78 . . . in a glass bottle displayed at Einhorn's store."²⁶ With this money, the captain bought linens, food and other commodities needed to care for the orphans. As Isaacs worked harder, and the flu began to subside, people continued to give. By the end of November, "the total amount collected . . . for the Lytton's Orphanage during

by reports," while cases in San Francisco experienced the "greatest gain since the appearance of the epidemic."³⁰ Though new cases would appear well into December and January, late October was the beginning of the end for Spanish flu in Sonoma County.

On Oct. 29, the *Press Democrat* happily reported that "only 14 cases reported Monday as compared to 21 Saturday."³¹ This decrease allowed local officials to reopen public services that had closed as a result of the flu. They "authorized the removal of masks," adding that, "people should not omit the ordinary precautions to prevent an outbreak of influenza again."³¹ As 1918 came to a close, the county was relatively healthy. Fear had subsided enough by mid-November to allow "the blowing of whistles, blowing of horns and the screech of auto horns as the news became public of the signing of the armistice."⁴

For about two months, the Spanish flu cut through Sonoma County, affecting nearly everyone. On Nov. 10, the *Press Democrat* reported "more than 500 cases."³² By one estimate, 175 people—about 2% of the county's population—died of the flu.⁴ However, the death toll was most likely higher. Many of the victims of the flu died from infections after living through the disease.³³ Pneumonia, tuberculosis, and other diseases, whose death tolls are not accounted for in the figures for the Spanish flu, also ravaged the community.³³ In addition, some deaths probably went unreported. Regardless of the precise number, the people of Sonoma County certainly suffered.

The Spanish influenza pandemic of 1918 killed millions of people throughout the world. In a period of only a few months, it destroyed a substantial portion of the earth's population. In Santa Rosa, hundreds from a community of only a few thousand perished within weeks. Yet, amid all this death, life went on. Citizens came together to lasso deer and to celebrate the end of World War I. And a girl writing to her mother expressed the hope that life would soon "go like good old times." ■

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References

1. Barry JM, *The Great Influenza*, Viking (2004).
2. McNeill WH, *Plagues and Peoples*, Anchor (1989).
3. Kolata G, *Flu: The Story of the Great Influenza Pandemic of 1918*, FSG (1999).
4. LeBaron G, *Santa Rosa: A Twentieth Century Town*, Historia (1993).
5. "Influenza Continues To Spread," *Press Democrat* (10 Oct. 1918).
6. "Influenza Has Appeared Here," *Press Democrat* (15 Oct. 1918).
7. "Pledged Pair Near in Death," *Press Democrat* (19 Oct. 1918).
8. Izzoni L, *Influenza 1918*, TV Books (1999).
9. "Caution Against Influenza Urged in Notice Sent Here," *Press Democrat* (9 Nov. 1918).
10. "All Gatherings Are Prohibited," *Press Democrat* (19 Nov. 1918).
11. "District Attorney," *Press Democrat* (31 Oct. 1918).
12. "Physicians Are Using Vaccine," *Press Democrat* (31 Oct. 1918).
13. "Wearing of Masks Is Made Compulsory by Authorities," *Press Democrat* (3 Nov. 1918).
14. "Fine or Jail for Everybody Who Does Not Wear Mask," *Press Democrat* (10 Nov. 1918).
15. "Number of Non-Mask Wearers," *Press Democrat* (2 Nov. 1918).
16. "Business College to Be Closed Next Week," *Press Democrat* (26 Oct. 1918).
17. "An Urgent Appeal to the Public," *Press Democrat* advertisement (27 Oct. 1918).
18. "The Luxury Tax," *Press Democrat* advertisement (7 Nov. 1918).
19. "Pessimism," *Press Democrat* advertisement (10 Nov. 1918).
20. "Protect Your Health," *Press Democrat* advertisement (16 Oct. 1918).
21. "Spanish Influenza," *Press Democrat* advertisement (23 Oct. 1918).
22. "Emergency Call for More Nurses," *Press Democrat* (29 Oct. 1918).
23. Little F, Letter to Gaye LeBaron (3 Dec. 1989).
24. "Drughouses in Quandary Call in 'Drummers,'" *Press Democrat* (22 Oct. 1918).
25. "153 Children Suffering from Influenza at Lyttons," *Press Democrat* (17 Oct. 1918).
26. "Money for the Orphans," *Press Democrat* (23 Oct. 1918).
27. "Collections for Sick at Lyttons Home," *Press Democrat* (23 Nov. 1918).
28. "Jean," letter to mother (22 Jan. 1919).
29. "Deer Lassoed and Caught in Rincon," *Press Democrat* (7 Nov. 1918).
30. "Influenza Has Run Its Course in the Army Camps; Coast Worse," *Press Democrat* (23 Oct. 1918).
31. "Influenza Is Slowly Fading," *Press Democrat* (29 Oct. 1918).
32. "44 Deaths At The State Home," *Press Democrat* (10 Nov. 1918).
33. LeBaron, Gaye. "Influenza Epidemic." Telephone interview. 20 Mar. 2009.





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SONOMA COUNTY
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MENDOCINO-LAKE
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AWARDS & COMEDY NIGHT GALA 2019

"A celebration with & for our medical community"



Santa Rosa Golf & Country Club was the setting for the Sonoma County Medical Association's 35th annual Awards Gala. More than 140 attendees and guests gathered on Friday, Jan. 24, 2020, to honor and celebrate achievements of their medical colleagues in 2019.

Prior to dinner and the award presentations, attendees enjoyed a reception and silent auction to support the Health Careers Scholarship program. Auction items donated by SCMA members, business partners, and supporters raised funds for local students pursuing careers in medical fields.

SCMA President Dr. Patricia May passed the gavel to incoming 2020 President Dr. Rajesh Ranadive, who welcomed guests and presented the awards. Winning auction bids were announced by SCMA Executive Director Wendy Young,

and comedian Bobby Tessel concluded the evening with a light-hearted presentation to acknowledge National Belly Laugh Day.

HEALTH CAREERS SCHOLARSHIP PROGRAM

Thank You, Silent Auction Contributors

Breast and General Surgeons / Sutter Medical Group of the Redwoods; California Medical Association; Christopher Creek Winery; Cooperative of American Physicians; Jeff Sugarman, MD; John Gnam and Jackie Senter, MD; Practice & Liability Consultants; Santa Rosa Golf & Country Club; Sheela Hodes and Tammra Borrall / Compass; Stanley Jacobs, MD and Eric Culbertson, MD / Aesthetic Plastic Surgery; Stillwater Spirits; Traditional Medicinals; Vintners Resort / Vi La Vita Spa

2019 AWARDEES



ANDREA RUBINSTEIN, MD

OUTSTANDING CONTRIBUTION TO LOCAL MEDICINE

In recognition of her efforts to reduce opioid risk for patients with chronic pain through her clinical practice at Kaiser Santa Rosa and for teaching and speaking across California for the past 12 years.



SHELLEEN DENNO, MD

OUTSTANDING SERVICE TO THE COMMUNITY

In recognition of her tireless contribution to hospital services and for helping transform West County's only acute facility into a resource that provides care to critically patients requiring extended hospitalization.



PETER SYBERT, MD

OUTSTANDING CONTRIBUTION TO SCMA

With gratitude for his many years of service on the Board of Directors and leadership in repositioning SCMA as a stronger, growing and more representative organization.



MARY SZECSEY

RECOGNITION OF ACHIEVEMENT

To honor her exceptional 25-year commitment as CEO of West County Health Centers, service on the Redwood Community Health Coalition Board, Sonoma County Health Action Council, and the California Primary Care Association.



MARY L. WILLIAMS, MD

ARTICLE OF THE YEAR

In appreciation of her article, "Climate Change, Public Health and 'Green' Medicine," which appeared in the fall/winter 2019-2020 issue of *Sonoma Medicine* magazine.



N. JAY FARRIS

PRACTICE MANAGER OF THE YEAR

In acknowledgement of his quest for continuous development of innovative, technical methodology as a tool for good and efficient support of the West County Integrative Medicine practice.



SCMA presentation platform; Dr. Nancy Doyle, John Gnam and Dr. Roger Pitzen; Naomi Fuchs, David Ebright and Daniel Rabkin; SCMA Executive Director Wendy Young.



Al Malasig and Dorine Leong (CAP); Dr. Patricia May accepts Sonoma Medicine plaque from Dr. Rajesh Ranadive and presents him with the presidential gavel; Corrina and Dr. Nikola Lozanov, N. Jay Farris and Dr. Robert Schulman.



Box left, clockwise fom top left: Awards are presented to Dr. Tabitha Washington (for Dr. Andrea Rubinstein), Dr. Shelleen Denno, Mary Szecey, N. Jay Farris, Dr. Mary L. Williams and Dr. Peter Sybert. Above: Drs. Richard Powers and Shelleen Denno, center left, with Dr. Denno's family and Gala attendees.



Comedian Bobby Tessel entertains guests.



Drs. Rajesh and Rajina Ranadive, with their daughter, Riya, and St. Joseph Health team.



Drs. David Vidauri, left, and Tabitha Washington (center) with their Kaiser Permanente team guests.

PHOTOS BY WILL BUCQUOY

DEPARTMENTS

- Catheter ablation of AF
- Pelvic organ prolapse
- "Mi Futuro" youth medicine symposium
- Book review: *Slow Medicine*
- Current clinical trials in Sonoma County
- Book review: *Arequipa Sanatorium*
- Emergency fund: Stick to a budget
- New SCMA and MLCMS members
- Physicians' Bulletin Board
- In Memoriam

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Catheter Ablation of Atrial Fibrillation: Outcomes and Expectations

Kriegh P. Moulton, MD, FACC, FACP, FCCP

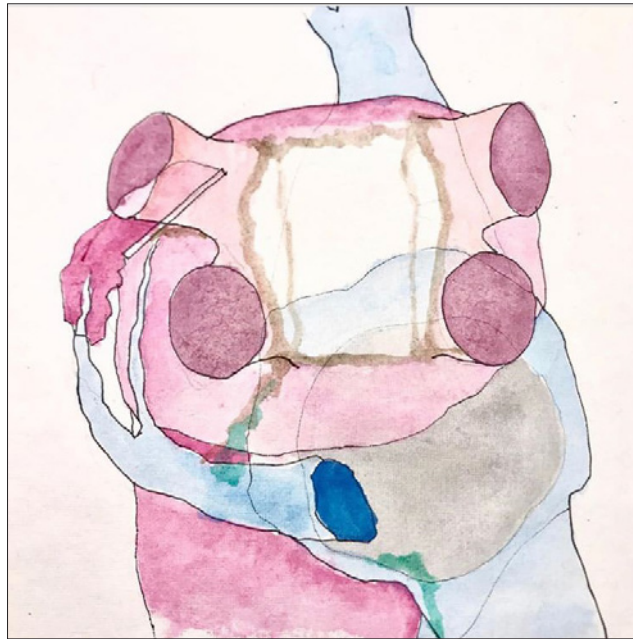
Atrial fibrillation (AF) has become the most common cardiac arrhythmia, particularly in elderly persons. A Kaiser Permanente cross-sectional study of patients enrolled in its health maintenance organization (the ATRIA Study, 2001) estimated that approximately 2.3 million U.S. adults currently have AF. It predicted that this figure will continue to increase to more than 5.6 million in the next 20 years.

While very uncommon in patients under the age of 40, it is seen in as much as 10 to 15 percent of patients over the age of 80, which is a quite a lot. Men are at greater risk than women. The most common conditions that underlie this arrhythmia include hypertension, obesity, obstructive sleep apnea, and alcohol excess. A significant portion of patients, particularly those under the age of 50, likely have a genetically based predisposition.

Atrial fibrillation is classified into four categories. *First diagnosed or new onset*: only one diagnosed episode; *paroxysmal*: recurrent episodes that stop on their own and



Dr. Moulton is a cardiac electrophysiologist with Northern California Medical Associates, Santa Rosa.



Watercolor painting of the left atrium as seen from behind, showing the most important perspective of the left atrium in the context of atrial fibrillation ablation.

ARTIST BING LIEM, DO, IS A CLINICAL PROFESSOR AT UCSF. SEE MORE AT BINGLIEM-ART.COM.

usually within no more than seven days; *persistent*: recurrent episodes lasting more than seven days and usually requiring cardioversion to restore sinus rhythm; *permanent*: continuous atrial fibrillation wherein a decision has been made to not restore sinus rhythm.

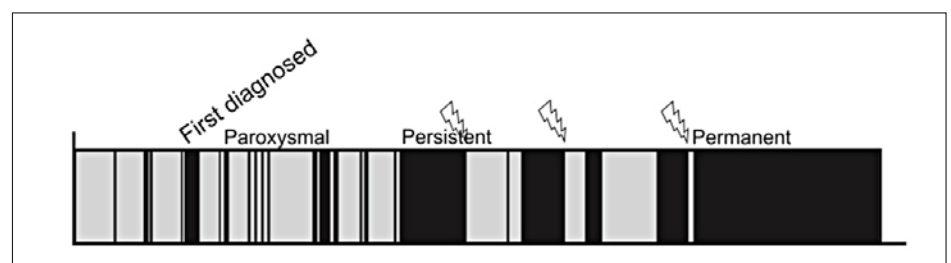
Natural Time Course of AF

From an etiological standpoint, the arrhythmia can also be classified according to coexisting structural heart disease or conditions. "Lone" atrial fibrillation implies an absence of any structural heart disease and is seen in younger populations. *Nonvalvular* atrial fibrillation exists in the absence of significant valve disease and includes such disorders as hypertension or coronary artery disease. The "valvular" reference emphasizes the importance of rheumatic mitral valve disorders, prosthetic heart valves, or mitral valve repairs, wherein a specific form of anticoagulation (warfarin) is necessary for the prevention of stroke. *Secondary* atrial fibrillation occurs in the setting of a

primary diagnosis such as hyperthyroidism, pericarditis, pulmonary embolism, cardiac surgery, pneumonia, or other infections, and may be reversible.

The majority of patients who develop AF exhibit a reasonably predictable progression from a paroxysmal to

Figure 1. Natural Time Course of AF



permanent behavior over time. Patients with “lone” atrial fibrillation tend not to progress as much, likely because of their younger age and absence of coexisting structural heart disease, which tends to promote a more persistent behavior.

Atrial fibrillation not only causes disabling symptoms such as palpitation, dyspnea, and activity intolerance; it can contribute to the eventual development of heart failure among patients with existing heart disease, particularly when the heart rate is uncontrolled. The second major consequence, embolic stroke, accounts for roughly 30 percent of all stroke cases. In one particular group of patients, those with asymptomatic atrial fibrillation, the risk of developing a “tachycardia-mediated” cardiomyopathy is significant. Luckily, the impairment in ventricular function is reversible once sinus rhythm is restored and maintained. This is also the subgroup of patients at even higher risk of stroke simply because they have no symptoms and never make it to the doctor’s office for a diagnosis.

Number of Concomitant Conditions

The actual risk of stroke is not just due to the presence of fibrillation. More importantly, it relates to the number of coexisting morbidities, which promote cardiac impairment, inflammation, and a more hypercoagulable state when *in the company of* fibrillating atria. The above graph emphasizes that as one progresses from paroxysmal to permanent, there is a greater proportion of patients having more coexisting morbidities. Or stated another way: as you own more risk factors, you are more likely to belong to the permanent group. The greater the number of these conditions in an individual, the greater the stroke risk. Hence, a system to establish the best advice to prevent stroke is based on a scoring system known as

the CHADS₂ VASC score (Figure 3), not on whether you are still experiencing atrial fibrillation.

CHADS₂ VASC Score

Added up, a score of 0 or 1 can be safely managed with aspirin regardless of the atrial fibrillation behavior (paroxysmal, persistent or even its duration at any time). A score of ≥2 prompts the

an occluding device has been developed for use in patients who are unable to take OAC drugs.

Management strategies are generally divided into rate control and rhythm control categories. Rhythm control refers to restoring and maintaining sinus rhythm using antiarrhythmic drug therapy or catheter ablation. The antiarrhythmic drugs to which I am

referring are “membrane stabilizing” drugs whose purpose is to prevent AF. Class I and III antiarrhythmic drugs are included in this category.

Rate control implies that the atrial fibrillation is left alone, but the ventricular response is kept within a normal heart rate operating range (50–80 bpm). This is achieved with medications that depress AV nodal conduction such as class II (beta blockers) and IV (calcium channel blockers) antiarrhythmic drugs. These drugs are not intended to *prevent* AF. The definitive endgame involves ablation of the AV node coupled with placement of a permanent pacemaker.

The AFFIRM trial showed no significant differences in all-cause deaths when comparing rhythm to rate control. Because this was somewhat counterintuitive, a more detailed analysis disclosed that the anticipated beneficial effect on survival by maintaining sinus rhythm

was offset by the adverse effects of the antiarrhythmic drugs used to maintain sinus rhythm. This is just one of many examples in which our treatment can be worse than the disease.

The recent randomized trial known as CABANA (Catheter Ablation versus Anti-Arrhythmic Drug Therapy for Atrial Fibrillation) intended to clarify this. It examined mortality outcome comparing ablation versus drugs in maintaining sinus rhythm. The trial showed only a *trend* toward improved mortality with catheter ablation. The

Figure 2. Number of Concomitant Conditions

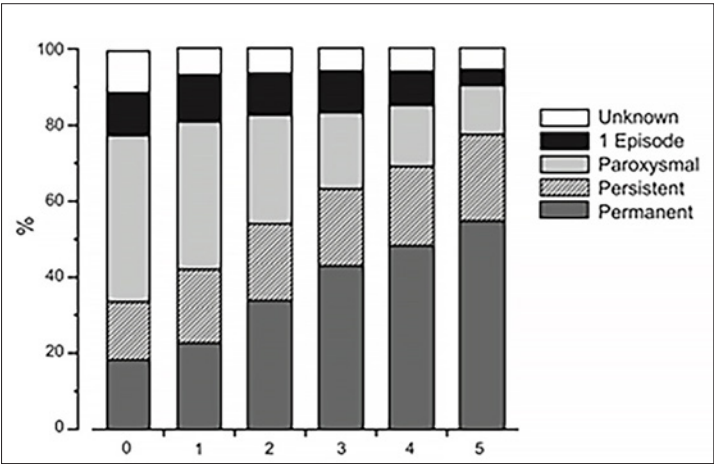


Figure 3. CHADS₂ VASC Score

	CONDITION	POINTS
C	Congestive heart failure	1
H	Hypertension	1
A	Age 65 or greater	1
A	Age 75 or greater	2
D	Diabetes mellitus	1
S ₂	Sex—Female gender	1
	Prior stroke/TIA	2
Vasc	Peripheral Vasc disease	1

recommendation for oral anti-coagulation (OAC) with either a novel anticoagulant such as dabigatran, rivaroxaban, apixaban, endoxaban, or with warfarin. Until our guidelines change, even if you think you have permanently eliminated the atrial fibrillation, OAC will be a lifelong requirement. Atrial fibrillation’s biggest morbidity is stroke, so there is no doubt that the most significant impact we have made in treating patients with AF is the ability to prevent stroke. Since the left atrial appendage is the source of the clots that embolize and cause stroke,

difference was not statistically significant. It's complicated. After a thorough reanalysis looking at the data as "per protocol" instead of the original "intention to treat" approach (which is what makes it a *randomized* trial), an ablation approach won out. The biggest criticism of the trial was that the reanalysis violated the rules of the game. Milton Packer (not related to Doug Packer, the primary investigator) aptly stated, "Why would you design a randomized trial if you are going to analyze it in a way that is inconsistent with randomization?"

Most electrophysiologists would agree that restoring and maintaining sinus rhythm is preferred to rate control, particularly in the younger patient, because it is easier to halt the arrhythmia progression by intervening earlier, at a time when the substrate is more likely to respond.

Pathophysiology

As is the case with nearly all sustained tachycardias, there is a requirement of a *trigger* to initiate the arrhythmia and a *substrate* to sustain it. Substrate refers to some structural feature of the involved cardiac tissue.

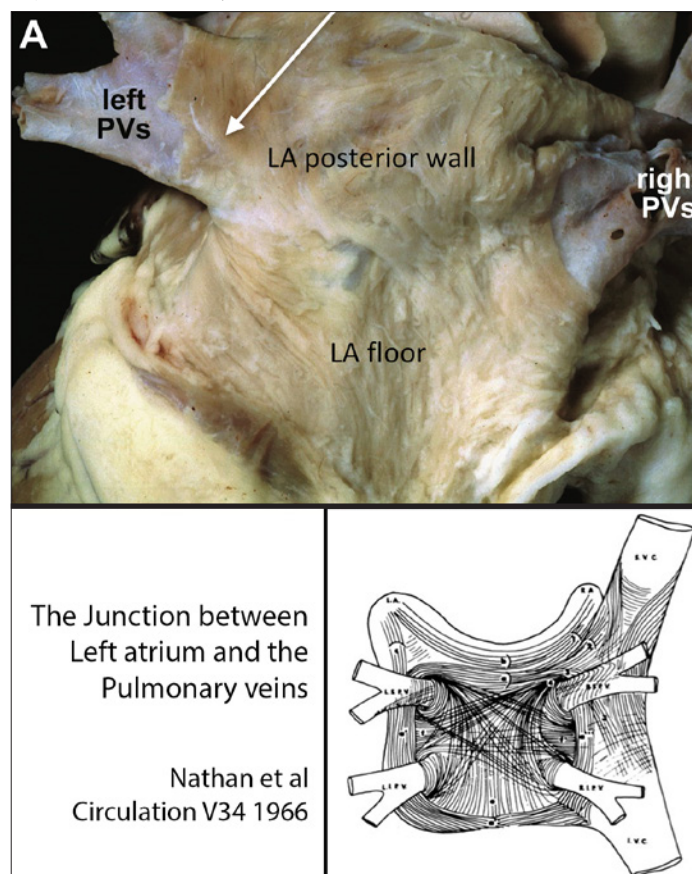
Pulmonary Vein Sleeve

Triggers appear in the form of premature atrial complexes or nonsustained atrial tachycardias. Their origins are predominantly from within the muscular sleeves that wrap around the base of each of the four pulmonary veins and provide an anatomic transition from cardiac (atrial) to vascular tissue. The basis for the arrhythmogenic behavior of the pulmonary vein sleeves relates to their cells' ability to develop abnormal pacemaker behavior—a mechanism referred to as "triggered" activity. Triggered activity stems from one's genetic make-up, but is also made worse by the volume or pressure overload conditions that accompany the various types of heart disease: cellular "stretch" is arrhythmogenic. Triggers also reside

within the left atrial posterior wall.

The substrate is primarily a reference to the structural features that exist within the left atrial muscle tissue and, in my view, extend to the entirety of the left atrial posterior wall. Here, complex myocardial tissue architecture, fibrosis, and abnormal neural activity promote the conditions that facilitate perpetuation of fibrillation once initiated by the triggers.

Figure 4. Pulmonary Vein Sleeve



Management Issues

The primary intent of this article is to provide better insight into the issues we commonly face in the management of atrial fibrillation. Three clinical circumstances are discussed: new onset atrial fibrillation, managing atrial fibrillation in the emergency room, and dealing with the asymptomatic patient. Additional commentary includes anticoagulation choices, selecting the proper antiarrhythmic drug, and some insights into ablation of atrial fibrillation.

The following four questions pertain to all clinical circumstances and should be taken into consideration when formulating an initial treatment strategy:

1. How long has the patient been in AF?
2. Is the patient currently adequately anticoagulated?
3. Is the patient really asymptomatic?
4. Are you going to use a membrane stabilizing antiarrhythmic drug (class I or III) or an AV nodal blocking drug (class II or IV)? They aren't the same thing.

New Onset or First Diagnosed Atrial Fibrillation

When a patient appears in your examining room and is found to be in atrial fibrillation for the first time, it's probably not the first instance—especially if he/she is unaware of it. Because the fundamental approach to managing AF is to prevent stroke and eliminate symptoms, step one begins with the appropriate antithrombotic agent based on the patient's CHADS₂/VASC score. That's the easy button.

Typical symptoms of atrial fibrillation include palpitation, racing heart, resting or exertional shortness of breath (elevated LV filling pressure), and activity intolerance (reduced cardiac output). Chest discomfort can occur. Syncope is rare. I would recommend a short-term event monitor (at least one-week duration) to establish if there is a more persistent behavior that

implies the likely need for cardioversion. If heart rate *average* exceeds 100 bpm, I would also initiate a beta blocker or calcium channel blocker (verapamil or diltiazem) to bring the rate under control until a definitive plan is formulated.

Cardioversion should be pursued if the AF is present 100 percent of the time on the event monitor, referred to as 100 percent burden. Because it is the patient's "first" episode, one has no idea when the next episode is likely to occur. Thus, there is no compelling reason to initiate antiarrhythmic drug therapy. The exception is if his/her average rate was over 100 bpm, in which case temporary "rate control" with an AV nodal

blocking agent would be just fine. If the next episode were not to occur for six months or more, placing the patient on drug therapy would be overindulgent. Imagine if you had one episode of AF per year. How long will it take to convince yourself the drug is working? The answer is two years *without an episode*. In general, I would want to give most or all patients the benefit of the doubt and embark on a rhythm control strategy if recurrences are subsequently observed regardless of symptoms.

For those patients who will go on to have recurrent episodes of AF, their frequency will determine whether they should have *maintenance* therapy or the “cocktail” approach. Maintenance therapy implies daily dosing while the cocktail approach involves a single, large dose of a membrane-stabilizing drug taken within an hour of onset, and not to be repeated in a 24-hour period. It’s like taking 800 mg ibuprofen for a headache. This approach is limited to the drugs propafenone and flecainide. As a guide, episodes occurring more frequently than one per month should be managed with maintenance approach while those fewer than one every three months could be handled with the cocktail approach. Your patient can certainly contribute to the decision-making on this topic.

Additional initial evaluation will include their past medical history, and looking for treatable disorders known to cause AF such as hypertension, thyroid disorder, sleep apnea, and alcohol excess. An electrocardiogram and echocardiogram will provide you with a good baseline assessment of cardiac structure and function, and give additional insight into other issues that may need attention.

AF in the Emergency Department

Invariably, patients presenting to the emergency room with AF are significantly symptomatic. The ECG findings are: no identifiable P waves and an irregular ventricular response. Often, there is no visible atrial activity at all, and the baseline seems flat. This still qualifies as “no identifiable P waves.”

The worst-case scenario is a patient with hypotension, angina, or heart failure symptoms in conjunction with their AF. Ventricular rate response is

usually rapid. Emergent cardioversion is most appropriate followed by temporary rhythm control until more information can be made available, and this includes their anticoagulation status.

The hypertensive patient with AF and rapid ventricular response is more readily approachable since drugs controlling rate generally also lower blood pressure. This patient and the one who is normotensive are not urgent concerns and don’t generally mandate DC cardioversion. Rather, the first consideration in these patients is the *duration of the atrial fibrillation*, as you should avoid restoring sinus rhythm if it has been ongoing for more than 48 hours and appropriate antithrombotic therapy has not been in place for at least three to four weeks.

Note that if warfarin is the patient’s anticoagulant, that three-to-four week period doesn’t begin until the day the patient has a therapeutic INR. Subsequent therapeutic INRs should be documented for the entire three-to-four week period. This is information you probably don’t have access to on a Sunday afternoon. If anticoagulation is inadequate or you don’t know, a rate control strategy should be initiated until three to four weeks of anticoagulation is completed. In cases involving adequate anticoagulation, intravenous ibutilide is a very good option to restore sinus rhythm enabling the patient to be discharged home in sinus rhythm. Caveats regarding ibutilide are found below.

For the patient who has not been anticoagulated, if the CHADS₂ VASC score is low (0 - 2) and they have been in AF <48 hours, it’s reasonable to restore sinus rhythm pharmacologically or by DC cardioversion. For scores >2, they may be better served with temporary rate control, initiation of appropriate antithrombotic therapy, and plans to restore NSR after three to four weeks. The fast-track alternative, especially for the symptomatic patient, is to perform a transesophageal echocardiogram to verify absence of left atrial appendage thrombus and then promptly proceed with DC cardioversion, with or without antiarrhythmic therapy. Follow up with an electrophysiologist should be arranged within the week.

The Asymptomatic Patient

The asymptomatic patient presents a problem for two reasons. One is because the duration of the arrhythmia is unknown. If the patient has not been adequately anticoagulated, sinus rhythm should not be restored until it is complete. If the patient is pondering whether he/she has symptoms in order to establish when the arrhythmia started, you must assume the duration is unknown.

The second reason is because there may be a tendency to assume sinus rhythm needn’t be restored—because, after all, there are no symptoms to eliminate. Most often, the mistake made here is that the patient actually does have symptoms but they are subtle. Not until sinus rhythm is restored, does the patient realize how good they really feel.

Anticoagulation and the CHADS₂ VASC Score

Once AF is documented, a commitment to antithrombotic therapy needs to be made. It needs to be made clear to the patient that it is a lifelong commitment. Only patients who qualify (according to guidelines) should receive a left atrial appendage occlusion device, as there can be significant risk surrounding the procedure. Also, it needs to be made clear that OAC must be continued indefinitely even when we think we have eliminated the arrhythmia by whatever means. A very big error of omission can occur when you stop anticoagulation believing you have eliminated the arrhythmia, and then a very long asymptomatic episode comes along and causes a stroke.

This brings up another unresolved issue: we still don’t know how much AF is enough AF to make stroke a real threat. This actually applies to both the decision to start anticoagulation and to justify its eventual discontinuation. Even if one had a perpetual implantable loop recorder, there’s no mechanism to mind the store often enough for it to be considered meaningful surveillance. Clinical trials are in place to answer this.

- CHADS₂ VASC score of 0 or 1: enteric coated aspirin, 81 (baby) or 325 mg.
- CHADS₂ VASC score of ≥2: warfarin, apixaban, rivaroxaban, dabigatran or endoxaban.

Choosing an Antiarrhythmic Drug

In the context of AF management, antiarrhythmic drugs are considered either membrane stabilizing drugs (class I or III) or AV nodal blocking agents (class II or IV). If your plan is to restore sinus rhythm, a membrane stabilizer should be your pick. For rate control, class II or IV drugs are best.

All class I agents block the sodium inward current, which has the effect of *impairing impulse conduction*, a form of antiarrhythmic drug action. All class III antiarrhythmic drugs *prolong repolarization* as the mechanism of antiarrhythmic action. However, please note we have never been able to apply the knowledge of these drug actions to tailor drug selection to a particular case in mind.

Drug Classes

When choosing an agent, one must know the underlying disease and the structural/functional features of the patient's heart, all available from the echocardiogram. The following are top choices, not the only choices.

Follow-Up Choices

- Flecainide and propafenone can be used with beta blockers, but with caution.
- Sotalol is more likely to cause *torsades des pointes* than amiodarone.
- QT prolongation is common to all class III drugs.
- Dofetilide and sotalol are the only drugs requiring three-day hospitalization to initiate.
- Ibutilide should be avoided in patients with low EF, low K⁺, or concomitant class III use.

Ibutilide is a particularly helpful drug in the emergency room. It is the only intravenous drug that can quickly convert AF to sinus rhythm by intravenous injection without creating bradycardia or dropping blood pressure.

Serious adverse effects are uncommon but include polymorphic ventricular tachycardia in patients with markedly reduced ejection fractions and/or hypokalemia. Its use has dramatically reduced the need for DC cardioversion and hospitalizations.

One should be familiar with the predominant routes of metabolism and excretion of all these drugs to avoid toxicity when used in patients with hepatic or renal impairment.

Figure 5. Drug Classes

DRUG CLASS	DRUG
IA	quinidine, procainamide
IB	mexilitene
IC	flecainide, propafenone
III	amiodarone, dofetilide, sotalol, ibutilide
II	beta blockers
IV	calcium channel blockers

Figure 6. Follow-Up Choices

No heart disease	flecainide, propafenone
Coronary artery disease	sotalol, amiodarone
Hypertension	flecainide, propafenone, amiodarone
Low EF (<45%)	amiodarone, dofetilide
Pre-existing low sinus rate	dofetilide
Best AF drug in the ER	ibutilide (Corvert)

Ablation of AF

Elimination of atrial fibrillation became a reality in 1998 when a group of electrophysiologists in Bordeaux, France, discovered that the origin of the AF triggers resides within the pulmonary veins. By ablating a circular area at the base of the vein where it is connected to the atrium, they were able to demonstrate that the spontaneous electrical discharges from within the vein were no longer able to propagate into the adjacent left atrium and the arrhythmia immediately became quiescent. This is referred to as pulmonary vein isolation (PVI).

Catheter ablation is a technique in which alternating current is delivered through the tip of an intracardiac catheter

in contact with a region of abnormal cardiac tissue to deliberately destroy it. As little as 15–30 sec of energy application can turn viable tissue into scar tissue. In principle, it is identical to the heat production during welding but with many orders of magnitude less current and voltage. Unlike household current (60 Hz frequency), the frequency used in catheter ablation is 600–700,000 Hz. Because this frequency is in the radio-wave range, the technique is referred to as radiofrequency catheter ablation.

Left Atrium

While there is a vast array of tools and considerable variation in the techniques used to perform catheter ablation, common to all is PVI. In my experience, the additional isolation of the entire left atrial posterior wall (PWI) results in even higher long-term success rates. Typically, PVI alone yields 60–75 percent success rate at one or two years. In my series of 350 patients undergoing both PVI and PWI, the 10-year success rate is 88 percent. Taking into account the learning curve, the success rate

during the last five years is 93 percent. Success means no symptoms and no drug. The percent of repeat procedures is only 15 percent, compared to 30–35 percent with PVI alone.

Figure 7 (following page) shows an example of the appearance of a patient's left atrium prior to (left) and following (right) combined PVI and PWI. The image is produced by moving a catheter with multiple electrodes throughout the left atrium. Because the heart is located within an electromagnetic field, the metal electrodes' locations are constantly tracked and the computer program "paints" a rendition of the shape of the chamber. The view is the rear of the left atrium with the four pulmonary veins projecting out (A–D). The color

reflects viability: purple is intact, excitable tissue, and red is inexcitable tissue. In the left-hand image, the portions of the pulmonary veins farthest away from the atrium are normally red because this region is “vein only” and venous tissue does not exhibit excitability. The base of each vein is purple, owing to the atrial muscle tissue known as the pulmonary vein sleeves.

Preablation, the sleeves, the posterior wall, and the remainder of the left atrium are all purple. In the right-hand postablation image, the black lines define the location of the ablation lesions placed with the catheter. Once completed and with no breaks in the lines, the ablation lesions prevent electrical activation of the portions of the atria and veins contained within the lines, rendering them electrically silent. It is remarkable that this much of the atrial wall can be rendered inactive and yet have little or no significant effect on overall cardiac function. Because the posterior wall also contains areas that are arrhythmogenic, sparing them is the reason the PVI-only success rates are between 60–75 percent and why there is a 30 percent repeat procedure rate within as little as two years.

Whom to Ablate

In general, the best candidates are symptomatic patients, whether or not they have failed drug therapy. Younger patients are more likely to benefit because we presume the disease process hasn’t progressed as far as it would have in older patients. Based on a recent meta-analysis as well as the CABANA trial, one population characteristic that is associated with improved mortality was having the ablation at ages under 65. As in the case with any type of therapy, the more frequent the symptoms, the sooner a successful result can be appreciated. If a patient was having an episode twice a year and underwent catheter ablation, it would take an entire year free of any symptoms to convince you

the procedure may have worked—and this just seems overindulgent.

Ablating asymptomatic patients is a bit more difficult to justify knowing that they will not recognize and appreciate what has been done to them, since they had no symptoms in the first place. But we do it and, to some extent, what really matters here is the operator’s procedural experience and his comfort level in performing it. Nothing is worse than having a procedural complication when the procedure’s benefit would never be obvious to the patient.

There is one category of the asymptomatic patient in whom catheter ablation is highly recommended: the patient who developed tachycardia—

the doubt, restore sinus rhythm, and give them an opportunity to see if they feel better. This often takes a couple of weeks to a month to sink in.

Morbidly obese patients are high risk for many reasons but, perhaps one of the more important ones is the excessive and avoidable amount of radiation that they would be exposed to if they were to undergo the procedure.

Outcomes and Expectations

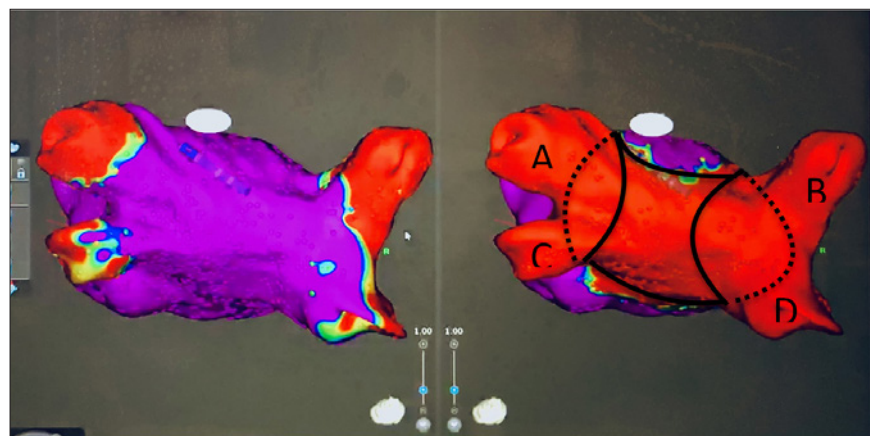
Most electrophysiologists do not maintain a database to track their own performance and it is not required by hospitals or professional organizations. As a result, their success rates are really a “gut feeling,” and one often quotes

the general experience as reflected in the literature. The literature does indicate a 60–75 percent success rate at one year for PVI-only, regardless of the technique: radiofrequency catheter ablation, the cryo-balloon method, or the “hybrid” approach in which your second procedure is actually being done anyway.

The hybrid approach, fashioned after the original surgical ablation technique, aims to ablate atrial tissue “from the outside” and requires thoracoscopy, either through the rib cage on both sides or a single access beneath the xiphoid process. Once the “epicardial” surgical approach is completed, you are scheduled to have the more traditional “endocardial” catheter ablation within a month or two. As this constitutes two initial procedures, success rates in some centers may be higher than reported. Of note is that the original surgical literature emphasized the importance of including the posterior wall in the isolation process.

In my series of patients, in addition to an overall success rate of 88 percent, the repeat procedure rate is only 15 percent, significantly less than the currently reported 30–35 percent rate of a second procedure. Three-fourths of the repeat procedures were performed

Figure 7. Left Atrium



cardiomyopathy because of a prolonged period of high heart rates that never got their attention. After their ablation, a special effort becomes necessary to verify that the patient stays in sinus rhythm. This is most easily accomplished by a daily heart rate determination (bp cuff, pulse palpation, pulse ox, Fitbit, or AliveCor). If a patient’s resting rate is always between 50–80 bpm, he/she is most likely in sinus rhythm. Resting rates in excess of 90 bpm are suspicious but resting rates over 100 bpm merit a closer look with an EKG. That’s when the AliveCor Kardia iPhone device really comes in handy.

One caveat is that many patients may deny the existence of any symptoms but, because the impact of the arrhythmia on their activity tolerance is subtle, they would have never known how good it was to be in sinus rhythm, until they’re in sinus rhythm. Therefore, one should always give the patient the benefit of

within the first two years after the index procedure. After that, the likelihood of a second procedure fell to a very low level. While a very late recurrence necessitating a second procedure occurred, it was unusual.

Follow-Up

Typically, I see patients at one, three, six, and 12 months post-procedure. If, at the 12-month visit, they are having no symptoms and were previously clearly symptomatic, I will discharge them from clinic. We can see them at any time in the future should the need arise. For the asymptomatic patient or those who developed a tachycardia-mediated cardiomyopathy, I follow them for two to three years, knowing this is the most likely timeframe a second procedure may become necessary. Nonetheless, they will be held to the responsibility of checking their resting heart rate on a daily basis.

Antiarrhythmic therapy is usually continued for two to three months post ablation and then stopped. We refer to this as the "blanking period" because in most all of the clinical trials examining ablation of AF, a very early recurrence of the arrhythmia didn't predict a later recurrence. Therefore, the patient is simply kept on a drug for a short period of time until the "dust settles."

In patients with a CHADS₂ VASC score of 0–1, OAC can be stopped at two months and they can resume aspirin. For all others, plan on lifelong oral anticoagulation until our guidelines change.

As a concluding comment: because AF is far more complicated than all of the other types of arrhythmias we ablate, one must remain vigilant to ensure all of the conditions known to cause AF, such as hypertension, coronary artery disease, sleep apnea, and alcohol excess, are kept under control. If not, the arrhythmia will be back. It's only a matter of time. ■

Ed. Note: In addition to his work as a cardiac electrophysiologist, Dr. Moulton and his wife, Linda Moulton, RN, have conducted courses on electrophysiology nationwide for the past 26 years.

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Recommended References

1. Schotten U et al, "Pathophysiological Mechanisms of Atrial Fibrillation: A Translational Appraisal," *Physiol. Rev.* 91:265-325, (2011).
2. Nault I et al, "Drugs vs ablation for the treatment of atrial fibrillation: the evidence: the evidence supporting catheter ablation," *Europ HJ* 31:1036-1054, (2010).
3. Ganesan A et al, "Long-term Outcomes of Catheter Ablation of Atrial Fibrillation: A Systematic Review and Meta-analysis," *J Am Heart Assoc* 10:1161-1173, (2013).
4. Packer D et al, "Effect of Catheter Ablation vs Antiarrhythmic Therapy on Mortality, Stroke, Bleeding and Cardiac Arrest among Patients With Atrial Fibrillation: The CABANA Randomized Clinical Trial," *JAMA* 321(13):1262-1274, (2019).
5. Calkins H et al, "2017 Consensus Statement on Atrial Fibrillation Ablation," *Heart Rhythm* 14(10):e275-444 (2017).



From left to right: Barbara Kangas, NP; Michael Yang, MD, and John Hau, MD

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Pelvic Organ Prolapse: Awareness and Treatment

Tara Bartlett, DO, FACOOG

Pelvic organ prolapse affects approximately 3 percent of women in the United States.¹ These women often suffer in silence, afraid to discuss their symptoms. They assume that they are the only ones dealing with this condition. Such patients may avoid social interactions, discontinue their favorite hobbies, or modify their work schedules due to symptoms related to pelvic organ prolapse. The good news is that for those with symptoms, treatment options are available to help.

Pelvic organ prolapse is a condition wherein the inside of the vagina bulges out through the vaginal opening. This may occur with descent of the uterus, cervix, bladder, rectum, or vaginal apex for those who have previously had a hysterectomy. This condition is not life-threatening as long as urination can occur normally. Some women do not have symptoms related to this condition and therefore do not need treatment. For others, symptoms may be life-altering. Depending on the severity of their symptoms, some women may want to pursue treatment options.

Patients experiencing symptoms may

Dr. Bartlett specializes in obstetrics and gynecology for Sutter Health, Santa Rosa, and serves on Sonoma Medicine's editorial board.



feel pelvic pressure or pain associated with routine activities or intercourse. They may feel like they are "sitting on a ball" or feel an external bulge vaginally. They can have urinary symptoms such as incontinence or retention. They can

My goal is that those suffering in silence will feel more at ease talking about their symptoms, knowing that there are options to help them.

experience an intense urge to urinate more frequently than average. They may have to strain with bowel movements or insert their fingers vaginally to assist in a bowel movement—a process called "splinting." Prior to engaging in intercourse, they may have to reduce the prolapse manually. This can be embarrassing to patients and thus a subject that they not eager to discuss with their

partner, friends, family, or even their doctor. All of these symptoms can lead to women suffering and prevent them from living a fulfilling life. However, pelvic organ prolapse is a commonly occurring problem that can be fixed if properly diagnosed and treated.

Pelvic organ prolapse can occur at any age. Risk factors for pelvic organ prolapse include: multiple vaginal births, poor tissue strength, collagen disorders, obesity, heavy lifting activities, chronic constipation, or chronic cough. Anything that puts pressure on the pelvic floor can contribute to pelvic floor weakening and can cause symptoms such as those listed. Once pelvic organ prolapse is diagnosed, it will progress and worsen over time at a variable rate.

For patients with these symptoms, the first step in diagnosis is a physical exam. The exam should be conducted by a gynecologist, urologist, or urogynecologist, depending on the availability in your community. At Sutter Santa Rosa Hospital, our gynecologists and urologists work together as a team in diagnosis, treatment, and surgical management. This condition can also be identified at a routine annual physical, during which a pelvic exam is completed by a family practice physician or advanced practice clinician. Once diagnosed, referrals should be made to those who can offer treatment.

The gold standard for examination is the POP Q exam or the Pelvic Organ Prolapse Quantification System.^{1,2}

This system was introduced in 1996 and measures different points in the pelvic anatomy to create a reproducible evaluation of a patient's prolapse. It serves to create a physical map of the vagina, vaginal apex, bladder herniation, or rectal herniation which can help diagnose, treat, and track progress before and after interventions. It can also help other physicians communicate the diagnosis with each other accurately.

Treatment options for pelvic organ prolapse are expectant management—

literally “watchful waiting, without active intervention,” pelvic floor physical therapy, pessary, or surgery. Expectant management is offered to those who do not experience bothersome symptoms and/or do not desire treatment. This option includes monitoring symptoms and completing exams annually, or sooner if needed. Pelvic floor physical therapy is a service that offers evaluation and treatment of the muscles in the pelvic floor. This is done by a trained specialist where an exam is performed

and specific muscles are targeted. An exercise regimen is created for exercises to be done at regularly scheduled office visits and at home. This may require multiple visits to continue to reassess progress and improve symptoms. In the latter stages of pelvic organ prolapse, these options may be ineffective to achieve patient satisfaction.

Alternatively, a pessary is a device that is inserted into the vaginal canal to support pelvic organ prolapse. The device is made of a soft, plastic-like material and it serves as an internal “shelf” to keep the prolapse from becoming an external protrusion. This product comes in different shapes and sizes. These devices require a fitting appointment at an office that offers such services, such as gynecology or urology. Pessaries require routine maintenance and cleaning every three months by the patient or by a physician if the patient is unable to remove the device herself. Benefits include improving symptoms and avoiding surgical risks. Risks associated with pessaries include vaginal erosions, vaginal discharge, and the need for medical visits every three months.

Lastly, surgery is an option to correct prolapse. Multiple procedures have been done historically and more continue to develop. Anterior and posterior surgical repairs can be done without abdominal incisions. An anterior repair or anterior colporrhaphy repair corrects a cystocele or bladder herniation into the vagina. A posterior colporrhaphy corrects a rectocele or rectal herniation into the vagina. Sacrospinous ligament fixation or uterosacral ligament fixation attempts to anchor pelvic organ prolapse to ligaments naturally found in the body.

A sacrocolpopexy is another procedure that requires entrance from the abdomen, via small incisions either laparoscopically or robotically. The procedure uses a mesh product in order to anchor the vaginal apex from the inside of the abdomen to the sacral bone in the pelvis. This creates “suspenders” from inside the abdomen to help correct the external pelvic organ prolapse from the inside of the body. This can be done with or without a hysterectomy, depending on the pelvic organ prolapse severity and the surgeon performing the surgery.

Bladder incontinence can occur after



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correction of a pelvic organ prolapse, as the anatomy has now been restored to its normal position and may affect the bladder area differently. Incontinence evaluation should be completed prior to surgery, and bladder sling procedures can be offered at the same time as pelvic organ prolapse surgical correction to prevent this condition.¹ These procedures can be offered in multiple permutations, depending on a patient's evaluation and management plan.

As with any surgery, risks include but are not limited to anesthesia effects, bleeding, infection, injury to other organs such as bowel or bladder, bladder incontinence, bladder retention, or recurrence of pelvic organ prolapse. Although risk rates are low with properly trained and experienced surgeons, informed consent includes a thorough discussion of the planned procedure in detail with the chosen surgeon before deciding on a treatment plan. Ultimately, the patient, with guidance from her physician, is the person who needs to decide on the next best step in treatment. Only these two parties know the effects prolapse is having on a patient's daily life activities, and the options available to remedy this particular patient's case.

My hope with this article is to make more people aware of this condition so that physicians can foster an environment where patients feel comfortable discussing these intimate symptoms. My goal is that those suffering in silence will feel more at ease talking about their symptoms, knowing that there are options to help them. This condition is readily identifiable and has varying treatment options suited to each person's comfort level. Through conversation and physical examination, treatment options can be offered to help patients improve their conditions, and live "restriction-free." Pelvic organ prolapse patients should no longer feel alone—because they are not alone. ■

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References

1. American College of Obstetrics and Gynecology, *Practice Bulletin Number 214*, "Pelvic Organ Prolapse," November 2019.
2. UpToDate, "Pelvic Organ Prolapse Diagnosis, Treatment, and Management."

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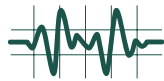
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Mi Futuro 2020: the North Bay's Annual Youth Healthcare Symposium

Tasha Vanden Heuvel

A beacon of warmth and hope on a cold January morning, the Grand Ballroom at Sonoma State University's Student Center beckoned more than 400 high school students from 25 high schools and four colleges to join Sonoma County healthcare professionals and volunteers for the 7th Annual Mi Futuro Youth Symposium. This much anticipated, sold-out event that promotes healthcare careers to local Latino youth took place on Friday, Jan. 10, 2020.

Expectations were high and the buzzing of excitement could be heard all the way downstairs as students flooded the third-floor ballroom. They were immediately immersed in the Justice Center, a forum of exhibitions from select agencies that advocate for education attainment, economic empowerment, and health access. Organizations included the Health Sciences Department at Santa Rosa Junior College, Wine Country Young Democrats, Sutter Health's "Future Faces of Family Medicine," Kaiser Permanente, the Santa Rosa Community Health Center, and Latino Service Providers.

One-on-one conversations between sponsors from these organizations and the students reinforced the



Tasha Vanden Heuvel is a freelance copywriter.



Anita MacInnis, clinical nurse educator at Kaiser Permanente (top left) and Dr. Elia Cole, (right) resident, Kaiser Permanente Family Residency Program, lead students in a hands-on demonstration.

symposium's mission to inform, motivate, and compel youth to consider careers in the mental health and primary healthcare fields. In a photo booth at the front area, students eagerly posed for the camera in scrubs and medical props, dreaming of "mi futuro."

And then everyone came together. Students took their seats around white linen-covered tables with personalized Mi Futuro cinch bags slung over their chairs. SSU Senior Elizabeth Camacho and Kaiser Permanente's Dr. Robert Martinez welcomed the youth and touched upon Sonoma County's human development index, explaining the effects of social and economic resources on life expectancy and education. Camacho explained, "If you live in central Bennett Valley, you are more likely to live nine years longer than if you live in the Sheppard neighborhood." And part of the reason, she

explained, is that 58.6 percent of the population in Bennett Valley has a Bachelor's degree compared to 8.6 percent in Sheppard. Mi Futuro is about reaching the under-resourced youth—244 first-generation college student hopefuls were present—with economic, social, and educational resources through healthcare career promotion. Simply put, Mi Futuro is health promotion.

Introducing the day's theme "Lived Experiences: Storytelling," Mi Futuro founder Musetta Perezarce, an RN at Kaiser Permanente, explained the day's itinerary and then

quite delicately walked the attendees through a slide that illustrated the effects that Adverse Childhood Experiences (ACEs) can have on health. With a rare transparency, she gave examples from her own childhood and her lived experiences as she modeled storytelling.

When asked what prompted her team to choose the theme "Lived Experiences: Storytelling," Perezarce responded, "It's easy to feel all that is wrong with our tough stories. Lived experience is about finding resources in our hard stories to make us more whole." She gave the students tools to structure their storytelling with soft edges, or boundaries, and to normalize their lived experiences by considering our local wildfires with respect to those around the country and the world.

PHOTOS BY NESTOR TORRES LUPERCIO



Participating physicians Dr. Rob Martinez, Kaiser Family Medicine Residency Program; Dr. Peter Valenzuela, chief medical officer, Sutter Medical Group of the Redwoods; and Dr. Chad Krilich, chief medical officer, St. Joseph Health.



Mi Futuro founder and chair, Musetta Perezarce, RN.

Instrumental in “setting the table” for the focus of the day was the first of three speakers, Dr. Peter Valenzuela, chief medical officer, Sutter Medical Group of the Redwoods. He encouraged students to follow their dreams while painting a sobering, yet inspiring portrait of his childhood. Dr. Valenzuela presented a true story of resiliency, rising above his 10/10 ACE score as a young boy to become the physician he is today.

Mi Futuro’s panel of speakers are members of the Physician Executive Team for the Committee for Healthcare Improvement (CHI), a group focused on promoting person-centered healthcare in Sonoma County. CHI is a coalition of healthcare providers and community health partners who are leading healthcare system improvement.

Using humor complemented by images on the large screen, the second speaker, Dr. Chad Krilich, chief medical officer, St. Joseph Health, encouraged attendees to pick themselves up when they fail and promised them that overcoming adversity would help them in the future. When asked his thoughts on the youth symposium, Dr. Krilich said, “Knowing this audience has experienced challenges, whether they be related to violence or otherwise, it was humbling to be present. What is even more awe-inspiring is that they want to work in healthcare. Being able to deliver my message was a privilege.”

Interspersed among the storytelling were activities created by Kaiser Permanente Family Medicine Residency to spark the students’ thinking regarding their own stories, sketching out

timelines of their lives, and imagining their futures. Dr. Patricia Hiserote, program director of Kaiser’s Family Medicine Residency program, said she enjoys working with Mi Futuro because it inspires healthcare providers of the future to join the workforce. “It’s exciting to work with these teens and expose them to the many career opportunities available to them. We are honored to be part of Mi Futuro and look forward to working with this community.”

Overwhelmed and grateful for this exposure, Raegan, a junior from Rancho Cotati High School, approached Perezarce during a break to inquire about internship opportunities. “I just feel so blessed to have the opportunity to attend this event,” she told Perezarce.

Back in their seats, the crowd was speechless once again as the third speaker, Dr. Jason Cunningham, chief executive officer, West County Health Centers, shared with heartfelt passion the value of every human and how relationships are the “secret sauce.” “One thing that endears me to Sonoma County, and something I have now seen tangibly through our collective trauma in the wildfires, is recognition of the benefit and importance of community.”

Hip-hop music broke the hushed silence and lightened the mood before lunch as Sonoma State’s Blue Baronz Dance Club took the stage to lead the students in a hand-hygiene dance. The power of dancing and laughing together bolstered the solidarity that had spread across the young crowd.

The afternoon that followed allowed students to rotate through various

stations, which ranged from workshops on mental health; self-care; and money and college; to the value of mentors. Students also had the opportunity to participate in hands-on med tracks led by residents from Kaiser’s Santa Rosa Family Medicine Residency. Dr. Hiserote explained, “One of the goals of our program is to train family medicine physicians who will serve our community. We support Mi Futuro because it is inspiring the healthcare clinicians who will one day take care of us!”

Without question, it’s the authentic and passionate testimonies, the invaluable resources, and the face-to-face contact provided by over 100 volunteers that gave students something to strive for, something to seek. Dr. Valenzuela said, “No one can touch the stars until they’ve reached the depths of despair and fought their way out.” By sharing his own challenges as an adolescent, he instilled hope and courage in the hearts of many students. He made overcoming adversity a realistic goal—a tangible dream.

“It was clear that these students were held tightly by a group of courageous leaders and thoughtful mentors who had a passion to empower a new generation of leaders and healthcare professionals. I have been in this business long enough to understand the commitment and love that is required to make something like this happen and am hopeful that these bright, young men and women will be more resilient as a result,” Dr. Cunningham remarked after the event. Hope was most certainly in the air. ■

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The Quality of Mercy

Brien A. Seeley, MD

Slow Medicine: The Way to Healing,

Victoria Sweet, 304 pages, Riverhead Books (2017).

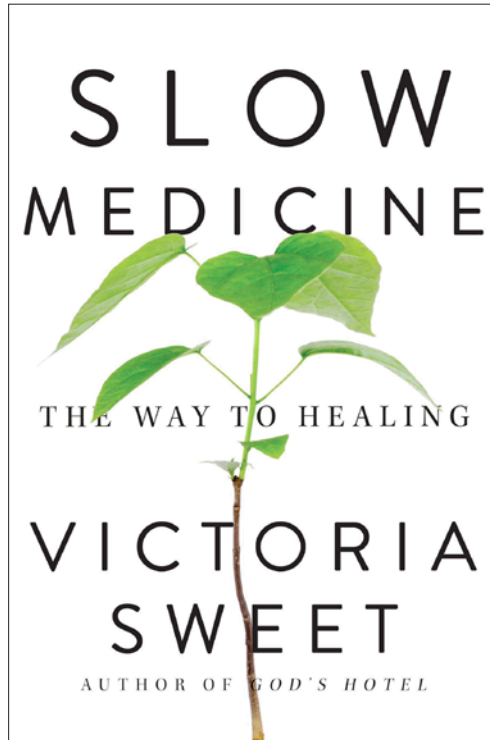
Who is going to biopsy that spot on your lung?" I asked my patient. "Sutter's going to do it," my patient said.

This incident shocked me as a bellwether event. This patient apparently identified his doctor as a soulless corporation rather than as a trusted, caring individual. It seemed that physicians today may be perceived as interchangeable technicians, mere clerks who hurriedly click through concocted EHR defaults, and who are too rushed under the strains of managed care to warmly connect with each patient's persona. Indeed, a 2016 study in *Annals of Internal Medicine* found that only 27 percent of a physician's time is spent delivering care to patients, while the rest is consumed with mainly administrative tasks.¹

Managed care, the system in which patients agree to visit only certain doctors and hospitals, and in which the cost of treatment is monitored by a managing company called a health maintenance organization (HMO), has become the dominant paradigm of care delivery. It has fractionated our population into medical "siloes" that are supposed to reduce costs, by competition, evidence-based care, and by creating large, too-big-to-fail systems that have economies of scale. Yet managed care siloes are criticized as being redundant,



Dr. Seeley is an ophthalmologist based in Santa Rosa.



top-heavy with management, and devoid of social equity, leaving millions of people uninsured and underserved. In reaction, a movement is afoot today to adopt "Medicare for All."

But MediCare for All faces obstacles. It is not a new idea. I recall an incident more than two decades ago, when several local physicians having their usual lunch together at Warrack Hospital were discussing managed care in the form of Medicare for All. One esteemed primary care physician warned, "You know what that would mean, don't you? That's where they'd put all of us [physicians] in the same bag, and then beat on that bag!"

Since then, managed care siloes and capitated HMOs have become pervasive, and their cost-driven low reimbursements, prior authorizations, expanded administrative and EHR burdens, and restrictive formularies are what seem to be "beating on the bag" of physicians.

As a result, we have seen many highly trained physicians driven to burnout, retirement, taking refuge in administrative jobs, converting to concierge practices, or switching to entirely private-pay cosmetic surgery—all of which exacerbate the physician shortage. And, for those who do continue to practice, the system strains their mercy, their willingness to invest in new medical technology, and their freedom to take the time to warmly connect with each patient. I wondered whether these strains might explain why my patient did not know or care which doctor was going to biopsy his lung lesion?

I found important insights about these and other issues in the engaging book titled *Slow Medicine: The Way to Healing* by Victoria Sweet, MD. The best books make you think, and *Slow Medicine* is surely such a book. It is much more than an insightful autobiography. Dr. Sweet describes how her life was changed by reading *Memories, Dreams, Reflections*, the classic book by Carl Jung about the internal confrontations of the male animus and the female anima in all of us. Jung's work inspired Dr. Sweet to go to medical school to become a psychiatrist, and reinforced what she believes to be her Aquarian destiny for contrariness and resistance to authority. "Subvert the dominant paradigm," seems to be her calling.

In *Slow Medicine*, Dr. Sweet does just that. What results is that *Slow Medicine* is to managed care what *Uncle Tom's Cabin* was to slavery.

Dr. Sweet describes her experience during the emergence of managed care as "more and more administrators were hired to oversee us. . . . There were more and more forms—five-page forms, ten-page forms, even twenty-page forms!—so many forms that the charts would explode from them, and

Medical Records would have to take out the doctors' notes to make room. There were more and more meetings, and the patients were sicker and sicker because, abandoned and ignored, they were at the bottom of the pecking order, no matter what Marketing said about Community and how the Patient Came First."

About HMOs, Dr. Sweet reasoned, "It sounded reasonable, in theory, to pay doctors to maintain their patients' health, but in practice my patients didn't have a lot of health for me to maintain. They didn't come to the clinic when they were healthy but when they were sick, and I would therefore have to get them healthy, and how was I going to do that? I had little say in the three determinants of my patients' health: their genetics, their luck and their choices. The only thing they themselves had control over was their choices, and where did that leave me? I could try to persuade them not to smoke, drink, take drugs, or have unprotected sex; to lose weight, wear their seat belts, take their medications, and get their X-rays, but I did that already and it wasn't particularly successful."

But *Slow Medicine* is so much more than a "tell it like it is" condemnation of managed care. It is vivid, personalized storytelling. Her description of her angst as a medical student took me back to my own days and nights of medical school and internship, to that cast of renowned medical professors, quirky attending physicians, battle-axe nurses, and the other characters who colored the intense learning experience of that great body of knowledge, both practical and scientific, that is a medical education.

Dr. Sweet defines "fast medicine" as the kind we are taught in medical school, with an immediate assessment and intervention guided by prevalent medical standards and using things like sterile instruments, needles, syringes, antibiotics, morphine, etc. She fully appreciates and uses fast medicine along with its alter ego, slow medicine. She defines slow medicine as analogous to the slow food movement. Both rely on what could be termed "savoring." In slow medicine this means the mindful opening of all one's senses to one's patient and being keenly attuned to emotional nuance. With this approach, she says, one can discover so much more

than by staring at fast medicine's EHR computer screen, with its scripted checklists, labs, and imaging studies.

It is slow medicine that comprehends holistic medicine and what Dr. Sweet recognizes as an essential life-force in everyone, a "viritidas." This viritidas is a main subject of Dr. Sweet's PhD thesis. It is a nature that is nurtured by warmth, kindness, trust and, sometimes, by simply being left alone to heal. Indeed, healing has actually been shown to depend upon patient perception²—the perception not only that their doctor is trustworthy, confident, and knowledgeable, but also warm, caring, and likeable. The wisdom to know when to let nature heal someone falls clearly in the camp of slow medicine rather than fast.

Most of the book is devoted to informal case presentations of her most memorable patients, each one providing a lesson learned and supporting her fundamental conclusion: quality medicine requires time.

The reader keenly feels her dilemma with each patient as she steers their care between fast and slow, tough love and compassion, protocols and practice, palliative care and healing. Her guiding principle throughout is that "the quality of mercy is not strained." She sees the built-in straining of mercy being foisted onto physicians by managed care and capitation as a dereliction of the broader societal responsibility for the costs of providing good medical care to all. Indeed, she argues that the physician is the last person whose mercy should be strained in a double bind. And yet they are strained.

Dr. Sweet asserts that capitation is predicated on the cynical assumption that a venal motivation in physicians will drive them to ration care in order to line their own pockets, while offering the disingenuous justification that it at least gives physicians the ultimate say in matters. Capitation entailed what Dr. Sweet calls a "volume up or die" mantra for what it took for physicians to survive. This mantra clearly imposes strains on the time and mercy that a physician can allocate for each patient.

The author derides the term "healthcare" as the merciless invention of accountants and utilization managers, a commodity traded on Wall Street. In

the book's Introduction, describing her 93-year-old father's poor quality hospital care, her disdain for "healthcare" is made clear:

"Everything looked so good in the computer, and yet what Father had gotten was not Medicine but Healthcare—Medicine without a soul. What do I mean by "soul"? I mean what Father did not get. Presence. Attention. Judgment. Kindness. Above all, responsibility. No one took responsibility for the story. The essence of Medicine is story—finding the right story. . . . Healthcare, on the other hand, deconstructs story into thousands of tiny pieces . . . for which no one is responsible."

About responsibility, she goes on to say, "This is what is so detrimental about algorithms, regulations, requirements and mandates. They lift that mantle of responsibility off the doctor and turn him or her into a provider, a middleman, someone who takes the box of healthcare off the truck and delivers it."

Dr. Sweet's tortuous career hopscotched from med school to psychiatric clinic, to locum tenens, internship, and residency with experiences that included private practice, a rural farm clinic, an STD clinic, an urgent care clinic, community and teaching hospitals, a PhD program, and then, finally, at Laguna Honda Hospital in San Francisco. As a hospitalist in a setting treating "a county's uninsured, unreimbursable sick poor," her most memorable therapeutic triumphs were consistently in complex patients who required extra time. She had to have the time needed for a thorough history, a mindful physical examination, a thorough chart review, and, equally importantly, sufficient follow-up visits to track and get to know how their disease process responded to various treatments. She presents compelling evidence that being rushed in delivering medical care is not only wasteful, but dangerous.

Dr. Sweet demonstrates how her memorable encounters throughout her career distilled a blend of empathy and wisdom that transcends the certitudes of evidence-based medicine and the dogma of fast medicine. Notwithstanding the current coronavirus pandemic, her idea of truly caring for the patient is to sit on their bed and look deeply into their eyes.

She declares that “although today there is a movement to discredit or even ban the physical examination as not ‘evidence based,’ not ‘objective,’ there is nothing better, more informative, than thoroughly examining a patient.” Dr. Sweet also extols the value of home-care visits as the way to really see, smell, and feel the life circumstances of one’s patient, and cites cases in which such intimacy proved crucial for finding an effective cure.

About the value of spending more time with patients, she says, “For example, patients would typically come in [to the hospital] on between fifteen and twenty-six medications, of which they actually needed only four or five. They would have accreted all those medications over the years, as their doctors, not having the time to discontinue a perhaps unnecessary medication in a stable patient, would simply renew everything. They would have gathered diagnoses, too, serious diagnoses they didn’t actually have, or had no longer—seizures, diabetes, hypertension, even cancer or AIDS—for which they were taking medication and getting lab tests. Establishing the correct diagnoses, and

then getting them off all those unnecessary medications, with their side effects and adverse reactions, took a lot of time, but in the long run it saved way more money than it cost. It was slower but it was better.”³

The author’s personal adventures remind us of the quality of mercy—that our most meaningful and memorable lessons learned are etched into our hearts and minds by heightened emotional challenges, whether they are embarrassing, heart-wrenching or gratifying. And Dr. Sweet shows us that such lessons learned almost always come from slow medicine, not fast.

Dr. Sweet’s book is devoted to the creed that mindfulness, rapport, and holistic awareness of each patient remain the core of good doctoring. In the face of the commoditization of medicine, she is a valuable keeper of the flame. ■

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References

1. <https://www.acpjournals.org/doi/10.7326/M16-0961?articleid=2546704&>

2. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3602922/discusses> using priming, client perceptions, and (3) the theory of planned behavior, to enhance the placebo effect. Research also suggests that the extent to which the client perceives the therapist as likeable and views him or her as an expert is highly important (Evans-Jones, Peters, & Barker, 2009). Recent research by Small, Taft, and Brown (2011) appears to support this assumption. Survey data indicated that when at-risk mothers were offered a social support intervention, the support was only considered beneficial if participants believed that the individual providing support was able to understand their situation and withhold judgment. An additional study conducted by Robinson and Serfaty (2008) suggests that displaying warmth and empathy may actually be the key factors influencing patient outcome, regardless of the physical attractiveness of the person giving care. Patterson (1985) identified that variables such as the perceived attractiveness and expertise, in addition to perceived warmth of the therapist have a significant impact on patient outcomes.
3. <https://journalofethics.ama-assn.org/article/complex-relationship-between-cost-and-quality-us-health-care/2014-02>. “Variation in prices paid by private insurers is due largely to bargains struck with doctors [16, 17], rather than quality of care.”

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OPEN CLINICAL TRIALS IN SONOMA COUNTY

Sonoma Medicine lists open clinical trials in Sonoma County to increase awareness of local medical research and to benefit physicians who may wish to refer patients. This list includes research groups that both responded to our request for information and are conducting open trials. The

clinical trials at other research groups are only open to their own patients.

Each listing includes the group's name and address, along with the phone number and email address of the appropriate contact person. As the list is subject to change, contact the individual research groups for the latest information.

If you know of other local open trials, contact SCMA at 707-525-4375 so the information can be listed in the next issue. This section is provided as a free service by *Sonoma Medicine*, and we rely upon voluntary input from the medical community in order to provide it. ■

NORTH BAY EYE ASSOCIATES

104 Lynch Creek Way #12, Petaluma
Contact: Eduardo Chavez
707-769-2240
research@northbayeye.com

Glaucoma

Glaukos

- iDose Intraocular Travaprost Implant for patients with Ocular Hypertension or Open Angle Glaucoma, Phakic or Pseudo patients on 2 or fewer glaucoma medications. Visual acuity of 20/80 or better. IOP 22- 36 mmHg, Pachymetry between 480 and 620 microns. Visual Field Defect required for OAG patients, no steroids permitted.

Allergan

- SLT Bimatoprost Sustained Release, biodegradable implants for patients with Ocular Hypertension or Open Angle Glaucoma that are non-compliant with their glaucoma medications and are suitable candidates for SLT. Washout of current medications is required. No use of steroids, Pachymetry between 480 and 620 microns. IOP 22-34mmHg.

Santen 5

- EP2 receptor agonist with non-prostaglandin structure for non-responders to Latanoprost. Ocular Hypertension or Primary Open Angle Glaucoma patients, washout of current medications is required. No steroid use or history of SLT, ALT, MIGS, PK, PRK or Lasik. Visual Acuity 20/80 or better, IOP off meds 22-34mmHg and Pachymetry 480-600 microns.

Nicox

- Evaluating the safety and efficacy of NCX 470 Ophthalmic Solution in lowering intraocular pressure (IOP) in patients with Ocular Hypertension or Open Angle Glaucoma.

Cataract surgery

Tarsius

- Investigate the safety and preliminary efficacy of TRS01 eye drops as compared to placebo on participants with ocular inflammation after cataract surgery. Participants must be over 18 and have undergone routine uncomplicated cataract surgery.

ST. JOSEPH HERITAGE HEALTH

3555 Round Barn Circle, Santa Rosa
Contact: Kim Young: 707-521-3814
kimberly.young@stjoe.org

Breast cancer

- Randomized Phase 3 trial evaluating the role of weight loss in adjuvant treatment of overweight and obese women with early breast cancer.
- An open label, randomized, Phase 2/3 study of olaparib plus pembrolizumab versus chemotherapy plus pembrolizumab after induction of clinical benefit with first-line chemotherapy plus pembrolizumab in participants with locally recurrent inoperable or metastatic triple negative breast cancer.

Colorectal cancer

- BESPOKE study of ctDNA guided therapy in colorectal cancer.

Head and neck cancer

- A randomized, double-blind, adaptive, Phase 2/3 Study of GSK3359609 or placebo in combination with pembrolizumab for first-line treatment of PD-L1 positive recurrent/metastatic head and neck squamous cell carcinoma.
- A Phase 3, randomized, open-label study to evaluate pembrolizumab as neoadjuvant therapy and in combination with standard of care as adjuvant therapy for Stage 3-4 A resectable locoregionally advanced head and neck squamous cell carcinoma.

Hematological oncology

- A Phase 1a/b trial to evaluate the safety and tolerability of CG-806 in patients with CLL/SLL or non-Hodgkin's lymphomas.

Infusion reactions

- TER-QZTR-001: A Phase 2 exploratory study of intravenous QUZYTIRTM (cetirizine hydrochloride injection) versus intravenous diphenhydramine in the prevention of hypersensitivity infusion reactions.

Lung cancer

- A Phase 1b study of venetoclax in combination with pembrolizumab in subjects with previously untreated NSCLC whose tumors have high PD-L1 expression.
- A Phase 2 study to evaluate the safety and efficacy of AB122 monotherapy, AB154 in combination with AB122, and AB154 in combination with AB122 and AB928 in front-line, non-small cell lung cancer.
- A Phase 3, open-label, randomized study of osimertinib with or without platinum plus pemetrexed chemotherapy, as first-line treatment in patients with

epidermal growth factor receptor (EGFR) mutation- positive, locally advanced or metastatic non-small cell lung cancer.

- MK7339-PN012: MK7339-012 Phase 3 study of pembrolizumab with concurrent chemoradiation therapy followed by pembrolizumab with or without olaparib in Stage 3 NSCLC.
- A biomarker-directed Phase 2 platform study in patients with advanced non-small cell lung cancer whose disease has progressed on first-line osimertinib therapy.
- A Phase 2, single arm study assessing the efficacy of osimertinib in combination with savolitinib in patients with EGFRm+ and MET+, locally advanced or metastatic non-small cell lung cancer who have progressed following treatment with osimertinib.
- A Phase 2 single-arm trial to investigate tepotinib in advanced (Stage 3B/4) non-small cell lung cancer with MET exon 14 (METex14) skipping alterations or MET amplification.
- A Phase 2 trial of pembrolizumab (MK-3475) in combination with platinum doublet chemotherapy and radiotherapy for participants with unresectable, locally advanced Stage 3 non-small cell lung cancer.
- A Phase 3, randomized, double-blind, placebo-controlled, multi-center, international study of durvalumab or durvalumab and tremilimumab as consolidation treatment for patients with Stage 1-3 limited disease small-cell lung cancer who have not progressed following concurrent chemoradiation therapy.

Multiple myeloma

- Expanded access program for belantamab mafodotin in patients with relapsed/refractory multiple myeloma who are refractory to a proteasome inhibitor, and an immunomodulatory agent, and an anti-CD38 antibody.

Myelodysplastic syndromes

- A Phase 3 randomized double-blind placebo-controlled study investigating the efficacy and safety of roxadustat (FG-4592) for treatment of anemia in patients with lower risk myelodysplastic syndrome (MDS) with low red blood cell (RBC) transfusion burden.

Prostate cancer

- A multicenter, randomized, open-label Phase 3 study of rucaparib versus physician's choice of therapy for patients with metastatic castration-resistant prostate cancer associated with homologous recombination deficiency.

Renal cell cancer

- An open-label, randomized Phase 3 study of MK-6482 versus everolimus in participants with advanced renal cell carcinoma that has progressed after prior PD-1/L1 and VEGF-targeted therapies.

Solid tumors

- A Phase 1, multicenter, open-label study to determine the safety, tolerability, pharmacokinetics, and preliminary efficacy of combinations of ABBV-927 with ABBV-368, buparlimab (ABBV-181) and/or chemotherapy in subjects with locally advanced or metastatic solid tumors.
- A multi-center, open-label, clinical study to evaluate the safety, tolerability, and pharmacokinetics of fruquintinib in advanced solid tumors.
- A Phase 2, open-label, single-arm, multicenter study to evaluate the efficacy and safety of pemigatinib in participants with previously treated locally advanced/metastatic or surgically unresectable solid tumor malignancies harboring activating FGFR mutations or translocations.
- A Phase 1/2, open-label, multi-center, first-in-human study of the safety, tolerability, pharmacokinetics, and anti-tumor activity of TPX-0005 in patients with advanced solid tumors harboring ALK, ROS1, or NTRK1-3 rearrangements.
- A Phase 1b/2 study of ibrutinib combination therapy in selected advanced gastrointestinal and genitourinary solid tumors.
- Open label Phase 2 study of Ladiratumumab Vedotin (LV) for unresectable locally advanced or metastatic solid tumors.
- Phase 1/2 basket trial of GPS in combination with pd1 checkpoint inhibitor and having a protocol designation of SLS17-201/MK3475-770.

Urothelial bladder cancer

- A study of enfortumab vedotin (ASG-22CE) as monotherapy or in combination with other anticancer therapies for the treatment of urothelial cancer.
- A prospective, non-interventional study to assess the prevalence of PD-L1 expression in the first-line setting of locally advanced/unresectable or metastatic urothelial carcinoma.
- A Phase 2, open label study of tucatinib combined with trastuzumab in patients with HER2+ metastatic colorectal cancer.

SUMMIT PAIN ALLIANCE

392 Tesconi Ct., Santa Rosa

Contact: Ahtziri Fonseca

Clinical Research Coordinator

707-623-9803, Ext. 118

afonseca@summitpainalliance.com

Lower back pain and/or leg pain

- Recharge Study: A multi-center, prospective, randomized, double-blind clinical trial of battery recharging optimization with the Senza® Spinal Cord Stimulator.

SYNEXUS RESEARCH

4720 Hoen Ave., Santa Rosa

Contact: Vicki Lynch

707-542-1469

victoria.lynn@synexus-us.com

Gastroparesis

- Phase 3 study in adults with or without diabetes who suffer from nausea, abdominal pain, postprandial fullness, bloating, vomiting and early satiety along with delayed gastric emptying.

Fibromyalgia

- Phase 2 study in males and females who meet the 2010 American College of Rheumatology criteria for fibromyalgia.

Diabetic peripheral neuropathy

- Phase 2 study in adults with Type 2 diabetes; HbA1c <11% with pain in extremities symmetrical in nature.

The Story of the Arequipa Sanatorium

David Lightfoot, MD

Arequipa Sanatorium: Life in California's Lung Resort for Women, Lynn Downey, 302 pages, University of Oklahoma Press (2019).

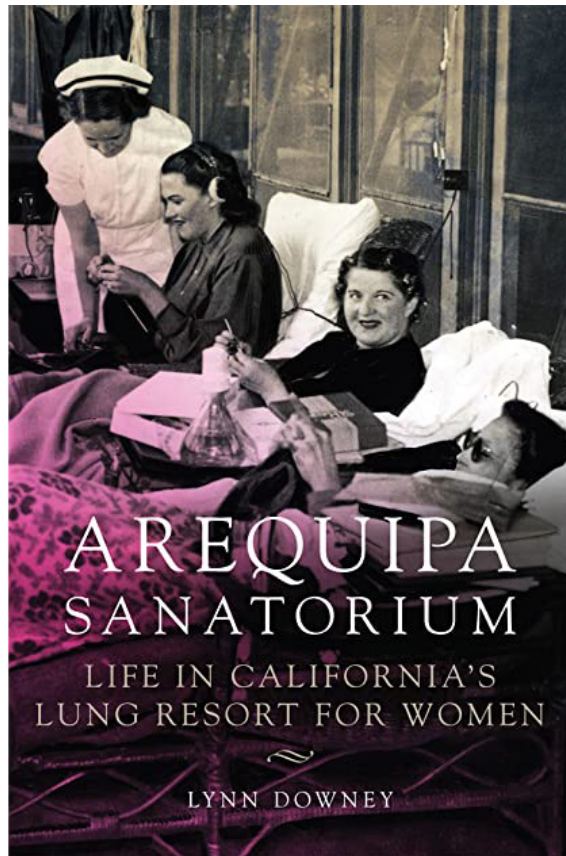
This is the story of the Arequipa Sanatorium, a unique tuberculosis hospital that was specifically designed to treat working class women from the Bay Area. It existed in Marin County from 1911 until 1957. The site is now the Northern California Girl Scout Council's Marin Day Camp at Arequipa, offering a progressive girls' leadership program, swimming, archery, leather crafting, cooking, and other activities for girls ranging in age from 5 to sixth grade. My wife Marsha once stayed overnight in the former sanatorium building, then known as the Brown House, as a "brownie." The building was demolished in 1984.

By the dawn of the 19th century, tuberculosis (TB), or consumption, had killed one in seven of all those who had ever lived. By the end of that century, TB,

"Captain of the Men of Death" (John Bunyan) was the second leading cause of death in the United States. TB is



Dr. Lightfoot is an ophthalmology specialist in Santa Rosa.



still one of the world's leading causes of mortality, with 10.4 million new diagnoses and 1.6 million deaths in 2017. But this book is much more than a history of a TB sanatorium.

Downey's interest in Arequipa was sparked by the realization that her paternal grandmother, Lois Boney Downey, was a patient there. After interviewing her grandmother about her 14-month stay, Downey came across an incredible trove of institution records that had been saved and stored in a shed by park ranger Happy Stanton. Years of research and interviews with staff and patients followed.

Downey's research predates the establishment of Arequipa. Using her grandmother's history to weave together the many strands of the story of Arequipa and its people, we artfully move from the present to the past, and back to the present. The rise of the progressive movement's empowerment of women in medicine and philanthropy is one theme developed. The founder of Arequipa, Philip King Brown, came from an unusual family. His mother, Charlotte Blake Brown, began medical school at Woman's Medical College of Pennsylvania in Philadelphia in 1872 with three children under 5 years of age. She helped establish the Pacific Dispensary for Women and Children in San Francisco, and later the first training school for nurses west of the Rockies. Her

brother, Charles Blake, Jr., and daughter, Adelaide Brown, were also physicians in San Francisco. Philip King Brown married Helen Hillyer, foster daughter of Phoebe Hearst, and women played a large role, not just in funding Arequipa, but as members of the board of trustees and management.

Another theme highlighted is the complex web of social and philanthropic connections that supported the establishment and maintenance of this private institution. The relationships among San Francisco elites are fascinatingly chronicled. The sanatorium was on land donated by Henry Bothin (the largest

individual commercial landowner in San Francisco at the turn of the 20th century), Mary and Luther Holton (mining and electric power), Jeanette Jordan (Boston and San Francisco real estate), Elizabeth Ashe (Asheville, N.C. family, nurse, and founder of the Telegraph Hill Neighborhood House and Hill Farm), Phoebe Apperson Hearst (mining), Blanche Wormser (S&W Fine Foods), Mary Raymond (B.F. Goodrich family), Isabel Kittle Dibblee (investment banking), Harriet Kittle (Kittle & Co., merchant), and Jacob and Sigmund Stern and Levi Strauss (Levi Strauss & Co.) were some of the social elite who supported Arequipa.

The American history of the rest cure, with exposure to fresh air, abundance of quality food, and freedom from stress is well journaled. The patients' viewpoint of their treatment is covered with engaging stories of their experience. Patients of all races, including African American, Chinese, Japanese, and Hispanic, were admitted to Arequipa. There was no segregation or differentiation of treatment by race or ethnicity, although the doctors and board members were

all white. The story of Rose, a Chinese American of 13 when first admitted, and who stayed five years as a patient before becoming a staff member and trained laboratory worker, is typical of the interesting stories told.

The society connections of the founder led to an exciting part of the Arequipa story: the pottery and tile made there. Artists Frederick Hurton Rhead, Albert L. Solon, and Fred Wilde led the works that were established along with basket weaving and other forms of occupational therapy—not only to occupy the patients' time, but also to give them a saleable skill so as to improve their life after discharge. These pottery and tile pieces are still very valuable and collectible.

The treatments the patients received are well covered. The use of the X-ray and fluoroscopy; the monitoring of weight and temperature; the importance of moving slowly so as to not irritate the lungs (the "TB glide"); and the importance of a positive mental attitude despite being separated from family, children, and friends were everyday routines. Less commonly used was

pneumothorax. Patients requiring more serious treatments, such as thoracotomy, were transported to a San Francisco hospital for the procedure and returned afterwards.

Finally, the story of what happened to the former sanatorium, the people who supported it, the people who worked there, and many of the patients of Arequipa is covered with personal detail seldom found in medical histories.

I heartily recommend *Arequipa Sanatorium*. ■

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For More Information

Lynn Downey is a fifth-generation Sonoma resident. She was the first in-house archivist and historian for the Levi Strauss Company in 1989 and is now an historical and archival consultant. She has authored six books, including Levi Strauss: The Man Who Cave Blue Jeans to the World, and A Short History of Sonoma. For more info, see www.lynnedowney.com.

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enjoy tours of housing, inventory and analysis of neighborhood, amenities and schools available.

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Sticking to a Budget Can Boost Your Emergency Fund

Russell Van Sistine

During the coronavirus pandemic, health concerns for ourselves and our loved ones have been at the top of our minds. But financial worries have been there, too—both for people whose employment has been affected, and for investors anxious about the volatile financial markets. And one aspect of every individual's total financial picture has become quite clear: the importance of an emergency fund.

Even in normal times, it's a good idea for you to keep three to six months' worth of living expenses in a liquid, low-risk account. Having an emergency fund available can help you cope with those large, unexpected costs, such as a major car repair or a costly medical bill. Furthermore, if you have an adequate emergency fund, you won't have to dip into your long-term investments to pay for short-term needs.

These investment vehicles, such as your IRA and 401(k), are designed for your retirement. So the more you can leave them intact, the more assets you're likely to have when you retire. And because they are intended for retirement, they typically come with disincentives, including taxes and penalties, if you tap into them early. However, as part of the economic stimulus legislation known as the CARES Act, individuals can now take up to \$100,000 from their 401(k) plans and IRAs without paying the 10 percent penalty that typically applies to investors younger than 59-and-a-half. If you take this type of withdrawal, you have up to three years to pay the taxes

and, if you wish, replace the funds, beyond the usual caps on annual contributions.

Mr. Van Sistine is a financial advisor with Edward Jones in Santa Rosa.

Of course, life is expensive, so it's not always easy to put away money in a fund that you aren't going to use for your normal cash flow. That's why it's so important to establish a budget and stick to it. When developing such a budget, you may find ways to cut down on your spending, freeing up money that could be used to build your emergency fund.

There are different ways to establish a budget, but they all typically involve identifying your income and expenses, and separating your needs from your wants. You can find various online budgeting tools to help you get started, but, ultimately, it's up to you to make your budget work. Nonetheless, you may be pleasantly surprised at how painless it is to follow a budget. For example, if you've budgeted a certain amount for food each month, you'll need to avoid going to the grocery store several times a week, just to pick up "a few things." That's because it doesn't really take that many visits for those "few things" to add up to hundreds of dollars. You'll be much better off limiting your trips to the store, making a list of the items you'll need, and adhering to that list. After doing this for a few months, see how much you've saved; it may be much more than you'd expect. Besides using these savings to strengthen your emergency fund, you could also deploy them toward longer-term investments designed to help you reach other objectives, such as retirement.

Saving money is always a good idea. When you use your savings to build an emergency fund, you can help yourself prepare for the unexpected and make progress toward your long-term goals. ■

Russell Van Sistine can be reached at 707-542-7071.



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magazine!

Welcome NEW SCMA MEMBERS!

James Hunt, MD, Ophthalmology*, Univ Southern California 1992

Sundari Mase, MD, Internal Medicine*, UC San Francisco 1993

Northern California Medical Associates (NCMA)

Kriegh Moulton, MD, Clinical Cardiac Electrophysiology, Univ Illinois 1983

St. Joseph Health Medical Group

Gregory Ackroyd, MD, Sleep Medicine*, Ross Univ 2000

Kurtis Birch, MD, Neurological Surgery, Boston Univ 2010

Dale Britt, MD, Emergency Medicine, Baylor Coll Med 1980

Deborah Britt, MD, Pediatrics*, Baylor Coll Med 1980

Frederick Drach, MD, Infectious Disease*, Tufts Univ 1979

R. Logan Faust, MD, Gastroenterology*, LSU New Orleans 1988

Gregory Houghton, MD, Critical Care Medicine,

Patrick Lally, MD, Family Medicine, Univ Minnesota 2012

Zachary Lewton, MD, Neurology*, Univ Rochester 1999

Cindy Scharfen, MD, Radiation Oncology*, UC San Francisco 1988

James Schneider, MD, MS, Surgical Oncology, St. Louis Univ 1985

Austin Sue, MD, Hospice & Palliative Medicine, Ross Univ 2012

Ye Thu, MD, Infectious Disease*,

Sutter Medical Group of the Redwoods (SMGR)

Jonathan Albeg, MD, Internal Medicine*, Univ Miami 1995

Frank Anderson, MD, Gastroenterology*, Boston Univ 1981

Renee Armstrong, MD, Family Medicine*, UC San Francisco 1994

Marjorie Bohn, DO, Pediatrics*, Western Univ Col Osteo Med 2006

Daniel Brenner, MD, Cardiovascular Disease, Boston Univ 2007

Ying Cao, MD, Hematology Oncology, Nanjing Med Coll 1999

Linda Casey, MD, Diagnostic Radiology*, Emory Univ 1987

Laurie Cederberg, MD, Family Medicine*, UC San Francisco 1988

Dorothy Coleman-Riese, MD, Pediatrics*, UC Los Angeles 1982

Emily Conway, MD, Cardiovascular Disease*, Brown Univ 2003

Allen Cortez, MD, Surgery*, Univ Michigan 1991

Leland Davis, MD, Pediatrics*, UC Los Angeles 1967

Paul Doemeny, MD, Diagnostic Radiology*, Georgetown Univ 2003

Tabitha Doniach, MD, PhD, Family Medicine*, UC Davis 2002

Thomas Duckett, MD, Urology*, Loyola Univ 1985

Max Duncan, DO, Clinical Neurophysiology*, Arizona Coll Osteo Med 1982

Sophie Fletcher, MD, Urology*, Univ Pittsburgh

Shawn Pejuta Franklin, MD, Emergency Medicine*, Harvard Med Sch 1996

Gary Furness, MD, Family Medicine*, Baylor Coll Med 1984

Cassandra Garcia, MD, Family Medicine*, Univ Vermont 1996

Karen Gelpman, MD, Family Medicine*, Univ Washington 1992

Robert Haimson, MD, Orthopaedic Surgery*, Stanford Univ 1987

Rex Harner, MD, Family Medicine*, UC Los Angeles 1973

Todd Hofeling, MD, Rheumatology, Univ Texas 2005

Donald Hopkins, MD, Cardiovascular Disease*, Baylor Coll Med 1978

Paul Hornberger, MD, Gastroenterology, Univ Rochester 1986

Aruna Jayaraman, MD, Gastroenterology, Jefferson Med Coll 1999

Natasha Kahl, MD, Obstetrics & Gynecology*, Albany Med Coll 1995

Sumit Kohli, MD, Gastroenterology*, Banaras Hindu Univ 1996

Lisa Kremer, MD, Rheumatology, Univ Minnesota 1989

Nicole Kwon, MD, Obstetrics & Gynecology, Rush Med Coll 2011

Jennifer Lee, MD, Family Medicine*, UC Davis 2006

Robert Lee, MD, Dermatology*, UC Los Angeles 2003

Helena Longin, MD, Dermatology*, Pennsylvania State Univ 2002

Michael Magnotti, MD, Endocrinology, Diabetes & Metabolism, New York Univ

J Mendius, MD, Neurology*, UC Los Angeles 1977

Jeremy Mesches, MD, Family Medicine*, New York Med Coll 1995

Jaime Molden, MD, Clinical Cardiac Electrophysiology*, Univ Chicago 2002

Thomas Neal, MD, Family Medicine*, Univ Southern California 1985

David Nguyen, MD, Hematology Oncology, Albert Einstein Coll Med

Jeannie Pflum, DO, Obstetrics & Gynecology*, Coll Osteo Phys Surg 1997

Mark Popovich, MD, Diagnostic Radiology*, Univ Southern California 1992

Matthew Pride, MD, Obstetrics & Gynecology*, Univ Washington 1992

Jesse Rael, MD, Diagnostic Radiology*, Univ New Mexico 1985

Mondhipa Ratnarathorn, MD, Dermatology*, UC Davis 2009

Bradley Restel, MD, Diagnostic Radiology*, Univ Texas 2005

Anthony Sajewicz, MD, Diagnostic Radiology*, SUNY Syracuse 2001

Emily Shaw, MD, Family Medicine*, Brown Univ 2010

Pooja Sherchan, MD, Endocrinology, Diabetes & Metabolism*, Punjab Univ 2001

Briant Smith, MD, Orthopaedic Surgery*, UC San Francisco 1986

David Soto, MD, Surgery*, Univ Illinois 1995

Christopher Stafford, MD, Internal Medicine*, Georgetown Univ 1998

Kari Teran, MD, Family Medicine*, Tufts Univ 1994

Tam Tiet, MD, Family Medicine*,

Rita Wang, MD, Obstetrics & Gynecology*, Univ Illinois 2006

Ashley Weinert, MD, Obstetrics & Gynecology*, UC San Francisco 1991

Jennifer Williams, MD, Family Medicine*, Univ Southern California 1984

Robert Woodbury, MD, Surgery*, Uniformed Services Univ 1992

Thomas Zembal, MD, Pediatrics*, UC San Francisco 1976

The Permanente Medical Group (TPMG)

Anita Baghaee, MD, Pediatrics*, Oregon Health & Science Univ 2017

Tram-anh Duong, DO, Geriatric Medicine, Touro Univ 2016

Virginia Heller, MD, Psychiatry, Univ Oklahoma 1993

Sharon Henderson, MD, Pediatrics*, Univ Maryland 2000

Thuan Thien Ho, DO, Internal Medicine, Touro Univ 2016

Jonathan Kramer, MD, Orthopaedic Surgery, Univ Southern California 2013

Quangminh Ly, MD, Internal Medicine, Tulane Univ 2016

Nicolas Mottola, MD, Pediatrics, Universidad Nacional De La Plata 2008

Lauren Pallis, MD, Family Medicine, Thomas Jefferson Univ 2015

Samuel Peaslee, MD, Family Medicine, Albany Med Coll 2016

Caroline Petrossian, MD, Internal Medicine*, Univ British Columbia 1991

Jessica August Saenz, MD, Infectious Disease, Ross Univ 2014

Joe Saenz, MD, Family Medicine, Ross Univ 2014

Craig Schier, MD, Family Medicine*, Med Coll Wisconsin 2008

Rashmi Sridhara, DO, Internal Medicine, Midwestern Univ Coll Osteo Med 2016

Gordon Tam, DO, Geriatric Medicine, Western Univ 2016

Jenny Vesona, MD, Obstetrics & Gynecology, Boston Univ 2009

Shu-Qing Yang, MD, Infectious Disease*, Sun Yat-Sen Univ 1984

* Board certified

Physicians' BULLETIN BOARD

IN THE NEWS

■ **St. Joseph Health Medical Group** is pleased to announce the opening of its new medical office building on July 8. The address is 1162 Montgomery Drive, Santa Rosa, CA 95405. The new offices offer a wide range of enhanced services including in-office registered nursing support, behavioral health services, on-site phlebotomy, and chiropractic services—and new offices for our PCPs and specialists. Learn more at www.stjosephhealthmedicalgroup.com.

News from Northern California Medical Associates

■ NCMA cardiologists **Patrick Coleman, MD**, and **Vishal Patel, MD**, are adding to Sonoma County's structural heart expertise. Both providers are now offering a minimally invasive alternative to open heart surgery—MitraClip™—the world's first transcatheter mitral valve repair (TMVr) therapy for patients with primary or secondary mitral regurgitation. This catheter-based approach to repair the mitral valve in beating hearts is performed at Santa Rosa Memorial Hospital. MitraClip has proven since 2003 to be a good option to alleviate mitral regurgitation without open-heart surgery for patients considered to be at high surgical risk.

■ **NCMA AI:** Patients and providers can find all NCMA provider contact information using common voice assistants like Siri (Apple), Alexa (Amazon), Cortana (Microsoft) and Google Home. Patients and providers can ask for phone numbers, addresses, hours of operation and more with simple voice commands. Some AI assistants can connect straight through to NCMA practices via phone, if asked to.

■ Lipid management, weight management, diabetes education, and prediabetes education classes and counseling are available at **NCMA Endocrinology and Diabetes Center** in Santa Rosa. Providers can refer patients directly to **Yuichiro Nakai, MD**, and directly to NCMA registered dietitian, **Jennifer Logan, RD, CDE**. More info: <https://www.ncmahealth.com/ncma-services/endocrinology/>.

To post an item on the Bulletin Board,
contact Rachel at 707-525-4375 or
rachel@scma.org.



In Memoriam



GEOFFREY ALLEN LEROY BOLT, MD



Geoffrey Allen Leroy Bolt, MD, of Sebastopol, Calif., died April 14, 2020, at age 87. Geoff was born in Gunnislake, Cornwall, U.K., in 1932 and grew up in nearby Calstock. He vividly remembered experiencing World War II as a young child and recalled seeing the

German bombing of nearby Plymouth. He earned his Bachelor of Medicine and Surgery from the University of Birmingham (U.K.) in 1957.

In 1961, he immigrated with his first wife Theresa Barnett and their young family to the U.S. for his medical residency. They eventually settled in San Francisco, Calif. Geoff married his second wife Margaret Hileman in 1970, and moved to Sebastopol in 1972, where he practiced internal medicine until retiring in 2000. He was chief of staff at Sebastopol's Palm Drive Hospital in the 1980s, and served as president of the Sonoma County Medical Association from 1984 to 1985.

After "retirement" at the age of 68, Geoff took classes in paralegal studies, writing, and pine-needle basketry. His English brother-in-law Peter rekindled his love of woodworking, and he often combined his woodturning with pine-needle weavings to create unique works of art. For several years he showed his art during open studios alongside his wife Maggie's, and son Dennis' artwork. When not traveling and visiting his family in England, he kept busy with gardening, fishing, cooking, reading, history, crosswords and jigsaw puzzles.

The last two years of his life he was able to live at home with the help of wonderful caregivers Mele and Izzy Radrodro and their team from Caring Friends Home Health Care agency. His quiet, cheerful personality will long be remembered by his many friends, colleagues, and patients. He is survived by his wife Margaret Bolt of Sebastopol, Calif.; sister Shirley Langman and nieces Julie and Andrea Langman of the U.K.; children Michael Bolt (Kathy) of Dell Rapids, S.D.; Susan (Jim) Kaye of San Diego, Calif.; David (Beth) Bolt of Scotts Valley, Calif.; Debbie Bolt of Dana Point, Calif.; and Dennis (JoVonne) Bolt of Sebastopol, Calif. He enjoyed the love of 11 grandchildren.

—The Press Democrat

ROSALYN MARGARET BROWN LEPLEY, MD



Rosalyn Margaret Brown Lepley, MD, 85, died following a short illness, on March 6, 2020, at Santa Rosa Memorial Hospital, surrounded by her loving family. Rose is survived by her brother, Donald Brown (Alice) of Bothell, Wash.; her sister, Josephine Roche of Napa, Calif.; her children Sacha

Lepley (John Wildgust), Alan Lepley (Cathy Damstra Lepley), and Lepley-Kurtz (Dustin Nishimura); seven grandchildren and three great grandchildren.

Born at Healdsburg Hospital on Oct. 19, 1934, to Kingston and Ellen Brown, Rose lived in Dry Creek Valley for much of her childhood. Her grandparents' farm is now the Warm Springs Recreational Area. On the path to becoming a medical doctor, Rose attended Santa Rosa JC, graduated from UCSF nursing school in 1957, attended UC Davis for premed classes and graduated from University of Minnesota Medical School in 1967. She then completed a Family Practice Residency at Santa Rosa Community Hospital in 1970, one of the first women to do so.

Rosalyn ran three private practices over the years, first in Santa Rosa from 1970–1973, then Granite City, Ill. from 1974–1986, returning to Rohnert Park/Santa Rosa in 1986 until she retired from solo family practice in 2006. After two years of retirement, she returned to work for another 10 years as a family practice doctor, working several days a week in Hollister, Clearlake, Lakeport Tribal Health and finally with Alliance Medical Center in Healdsburg until 2018. As a solo practitioner, for many years she shared on-call duties with Drs. David Bloom and Phyllis Senter, performed C-sections when necessary, assisted on surgeries, and trained resident family MDs and nurse practitioners.

Delivering babies was one of Dr. Lepley's joys during her practice of family medicine, allowing her to take care of the whole family. She delivered at both Community and Santa Rosa Memorial hospitals, and during her career delivered at least 2,000 babies and sometimes three generations!

Besides working in medicine, Rose enjoyed reading, cooking, gardening, thrift store shopping, having pool party BBQs and meeting people from all over the world. Over the last few years, she was able to travel several times to England, Ireland and Italy with family members. Her calm energy, companionship, cooking and wisdom are sorely missed.

—The Press Democrat

GRANT LINDEE, MD



Grant Lindee, MD, 64, of Healdsburg, Calif., passed away suddenly on Aug. 14, 2019, after a brief illness. Grant was born in Denver, Colo., and moved with his family to California when his father accepted a position as associate dean of the medical school at Stanford. Grant

returned to Colorado to attend the University of Colorado in Boulder, where he graduated Phi Beta Kappa. He studied medicine at Tufts University on an armed forces scholarship and joined the U.S. Medical Corps upon graduation. It was during his radiology residency at Letterman Army Medical Hospital in San Francisco that he met Christa, the woman with whom he would share the rest of his life.

The couple moved to Honolulu, Hawaii, where Grant served as staff radiologist at Tripler Army Medical Center, achieving the rank of major. Grant was deployed to Saudi Arabia during the Gulf War and served his country honorably in Operation Desert Storm. Grant and Christa returned to California in 1992, when Grant accepted a job with Kaiser Permanente in Santa Rosa. It was there they set down roots and started a family. Grant was a dedicated diagnostic radiologist and remained with Kaiser for 28 years. His unmatched work ethic was an inspiration to his colleagues and patients.

Grant always had an adventurous spirit and was happiest when he was cruising the back roads of Sonoma County and beyond on his Vespa. He also enjoyed exploring the Southwest, gardening, and was learning to golf. Through his devotion, Grant provided a wonderful life for his family and their many beloved pets. He was an excellent role model, instilling core values that will serve his sons for life.

Grant was preceded in death by his father Robert Lindee. He is survived by his wife Christa, his sons Robert and Peter, his mother Marjorie, his brother Mark (Deborah), his sister Anne Lindee Hoyt (Scott), his nieces Erinn and Kristen Hoyt, Rachel and Shannon Lindee, Kirsten Lindee Ferguson (Patrick), his grand nieces Wyatt, Jack and Ada Ferguson. He is also survived by his in-laws, Bob and Judy Staggs, and his beloved pets Tasha and Toby.

—The Press Democrat

In Memoriam continues on page 72



GEORGE PERCY ROSTEL, MD



George Percy Rostel, MD, passed away in Santa Rosa, Calif., on March 7, 2019, at the age of 93. He was born in Fargo, N.D., the son of a dermatologist and an opera singer, both immigrants from Germany. At age 17 George left home to attend Stanford University for

his undergraduate education. George graduated from Yale Medical School at 23, earning his MD. While at Yale, he met his beloved wife, Ilse. George and Ilse moved to Sonoma County in 1953, where he opened a pediatric practice and was devoted to his patients.

Upon retirement, he began working as a family therapist. George had many interests and hobbies. He had a lifelong love for magic. He was a long-time member of the Brotherhood of Magicians. He loved all aspects of magic: performing, the history, collecting magic effects and also meticulously refurbishing them. In addition, he enjoyed woodworking, classical music, fine art and reading, and his beloved dogs. He spent countless hours working on projects in his shop using meticulous care to perfect his project of the moment. In George's words, he wanted his remembrance to be that "children loved him and he was a little nuts."

George was devoted to his wife, Ilse, who preceded him in death in 2002. He is survived by his children, Laura Morita (Ken) and Chris Rostel (Drue); grandchildren, Emily, Hilary, Katie and Sam, and great grandchildren Josie and Maya.

DAVID A. SISLER, MD



David A. Sisler, MD, passed away peacefully at his home with his ever-present family at his side on Thursday, March 1, 2018. He was a loving and devoted husband, and is survived by his wife Cleo Emily Sisler. Dr. Sisler was a cherished father to his 11 children, an adored grandfather of 24 and great-grand-

father to 15—considered a father to others. He was a loving brother to the late Edwin Sisler and Richard Sisler, and is survived by his brother Albert Sisler and sister Barbara Kjolhaug.

Born in Grand Rapids, Minn. in 1927, "Doc" was raised by his dear parents Clifford and Ella Sisler. He graduated from the University of Minnesota Medical School (just like his father) in 1953. He became an Army Captain and was stationed at Tripler Army Hospital in Honolulu, Hawaii. Dr. Sisler came to Petaluma in 1957, created El Rose Medical Group, and built his office in 1960—practicing family medicine until he retired in 2013 at the age of 86. He was the football doctor for Petaluma High from 1957–2011 and an honored community member of Rotary and Old Guard for the Sonoma County Trailblazers.

Doc loved his patients and his family practice. His bedside manner was unlike any other. His life was his family and many friends. His favorite place was his ranch known as Medicine Mountain in Petaluma, and he had a great love for his many horses. He could often be found sitting outside watching the birds, smoking his corn cob pipe, and reading a Louis L'Amour novel. A rare country doctor who will be forever missed.

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